# 1995

# Illinois Register

## Rules of Governmental Agencies

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Index Department
Administrative Code Div.
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Springfield, IL 62756
(217) 782-7017

published by
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Secretary of State

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**Editor's Note:** The Cumulative Index and Sections Affected Index will be printed on a quarterly basis. The printing schedule for the quarterly and annual indexes are as follows:

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| April | 14, 1995 - Issue 15: Through | March | 31, 1995 |
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DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Services Delivered by the Department

2) Code Citation: 89 Ill. Adm. Code 302

3) Section Numbers: Proposed Action:

| | |
|---|---|
| 302.310 | Amend |
| 302.311 | Repeal |

4) Statutory Authority: 20 ILCS 505

5) A Complete Description of the Subjects and Issues Involved: These amendments revise the eligibility requirements for adoption assistance by redefining the requirements necessary to be considered a child with special needs and by establishing a new method of calculating the amount of ongoing monthly adoption assistance, which takes into account, after eligibility has been established, the specific circumstances of the adoptive parents and the special needs of the child being adopted. The amendments implement the provisions of Public Act 89-21 and provide that the Illinois program is consistent with Federal law. Public Act 89-21 established the adoption assistance ongoing monthly rate at least $25.00 less than the monthly cost of care in a foster home, as set forth in the annual adoption assistance agreement.

6) Will these proposed rules replace an emergency rule currently in effect? Yes

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed rules contain incorporations by reference? No

9) Are there any proposed amendments to this Part pending? Yes

| Section Numbers | Proposed Action | Illinois Register Citation |
|---|---|---|
| 302.300 | Amend | November 3, 1995 (19 Ill. Reg. 15120) |

10) Statement of Statewide Policy Objectives: These rules do not create or expand a state mandate as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3(b)].

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Comments on this proposed rulemaking may be submitted in writing for a period of 45 days following publication of this notice. Comments should be submitted to:

Jacqueline Nottingham
Chief, Office of Rules and Procedures



DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF PROPOSED AMENDMENTS

Department of Children and Family Services
406 East Monroe, Station #222
Springfield, IL 62701-1498
(217) 524-1983 or TTY: (217) 524-3715

The Department will consider fully all written comments on this proposed rulemaking submitted during the 45-day comment period. Comments submitted by small businesses should be identified as such.

12) Initial Regulatory Flexibility Analysis: These rules do not affect small businesses.

13) Regulatory Agenda on which this rulemaking was summarized: January 1995

The full text of the proposed amendment begins on page 16737

DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Illinois Promotion Act Programs

2) Code Citation: 14 Ill. Adm. Code 510

3) Section Numbers: Proposed Action:

510.150 Amendment

4) Statutory Authority: Implementing and authorized by the Illinois Promotion Act [20 ILCS 655].

5) A Complete Description of the Subjects and Issues Involved: Section 510.150 of the Tourism Attraction Grant Program rules is being amended to reflect recent legislative action. Public Act 89-262 increases the maximum amount of funds allowable for grants/loans to develop or improve tourist attractions.

6) Will these proposed amendments replace an emergency amendment currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Do these proposed amendments contain incorporations by reference? No

9) Are there any amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create or expand a state mandate as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3(b)].

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Interested persons may present their comments concerning this proposed rulemaking in writing within 45 days after this edition of the *Illinois Register* to the following:

Ms. Donna Shaw, Deputy Director
Bureau of Tourism
Department of Commerce and Community Affairs
100 West Randolph, Suite 3-400
Chicago, Illinois 60601
(312) 814-4733
T.D.D. (217) 785-6055

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses and small municipalities affected: These amendments will affect small municipalities by making it easier to obtain additional funds.



DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF PROPOSED AMENDMENTS

B) Reporting, bookkeeping or other procedures required for compliance: None

C) Types of professional skills necessary for compliance: Applicants would already possess the necessary skills for compliance.

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF PROPOSED AMENDMENTS

TITLE 14: COMMERCE
SUBTITLE C: ECONOMIC DEVELOPMENT
CHAPTER I: DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

PART 510
ILLINOIS PROMOTION ACT PROGRAMS

SUBPART A: TOURISM MATCHING GRANT PROGRAM

Section


SUBPART B: TOURISM ATTRACTION LOAN AND GRANT PROGRAM

Section


SUBPART C: TOURISM PRIVATE SECTOR GRANT PROGRAM

Section




DEPARTMENT OF COMMERCE AND COMMUNITY AFFAIRS

NOTICE OF PROPOSED AMENDMENTS



AUTHORITY: Implementing and authorized by the Illinois Promotion Act [20 ILCS 665].

SOURCE: Filed December 30, 1977; codified at 6 Ill. Reg. 15011; emergency amendment at 14 Ill. Reg. 13298, effective August 6, 1990, for a maximum of 150 days; emergency expired January 3, 1991; amended at 15 Ill. Reg. 2673, effective February 1, 1991; amended at 15 Ill. Reg. 8848, effective June 10, 1991; emergency amendment at 17 Ill. Reg. 22096, effective December 13, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 5813, effective April 1, 1994; amended at 18 Ill. Reg. 8387, effective May 23, 1994; amended at 20 Ill. Reg. _____, effective _____.

SUBPART B: TOURISM ATTRACTION LOAN AND GRANT PROGRAM

**Section 510.150 Funding Limitation**

The Department shall provide no more than 50 percent of the entire amount of actual expenditures for a single project, not to exceed $100,000 ~~$40,000~~.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Sport Fishing Regulations for the Waters of Illinois

2) Code Citation: 17 Ill. Adm. Code 810

3) Section Numbers: Proposed Action:

| | |
|---|---|
| 810.37 | Amendments |
| 810.45 | Amendments |
| 810.60 | Amendments |
| 810.70 | Amendments |
| 810.80 | Amendments |
| 810.90 | Amendments |

4) Statutory Authority: Implementing and authorized by Sections 1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5 of the Fish and Aquatic Life Code [515 ILCS 5/1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5]

5) A Complete Description of the Subjects and Issues Involved: In Section 810.37, additional definitions are being added; in Section 810.45 amendments to individual site specific fishing regulations by fish species or group are proposed; in Section 810.70, the "Free Fishing Days" are updated to 1996 dates; and in Sections 810.80 and 810.90, references to Department of Conservation are updated to Department of Natural Resources.

6) Will this rulemaking replace any emergency rulemaking currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed rulemakings pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not affect units of local government.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Comments on the proposed rule may be submitted in writing for a period of 45 days following publication of this notice to:

Jack Price
Department of Natural Resources
524 S. Second Street, Room 430
Springfield, IL 62701-1787
217/782-1809



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

12) Initial Regulatory Flexibility Analysis: This rule does not affect small businesses.

13) Regulartory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Amendments begins on the next page:

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

TITLE 17: CONSERVATION
CHAPTER I: DEPARTMENT OF CONSERVATION
SUBCHAPTER b: FISH AND WILDLIFE

PART 810
SPORT FISHING REGULATIONS FOR THE WATERS OF ILLINOIS

Section


AUTHORITY: Implementing and authorized by Sections 1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5 of the Fish and Aquatic Life Code [515 ILCS 5/1-120, 1-125, 1-150, 5-5, 10-5, 10-10, 10-15, 10-20, 10-25, 10-30, 10-35, 10-45, 10-50, 10-60, 10-75, 10-90, 10-95, 15-50, 20-5, 20-35 and 25-5].

SOURCE: Adopted at 5 Ill. Reg. 751, effective January 8, 1981; codified at 5 Ill. Reg. 10647; amended at 6 Ill. Reg. 342, effective December 23, 1981; amended at 6 Ill. Reg. 7411, effective June 11, 1982; amended at 7 Ill. Reg. 209, effective December 22, 1982; amended at 8 Ill. Reg. 1564, effective January 23, 1984; amended at 8 Ill. Reg. 16769, effective August 30, 1984; amended at 9 Ill. Reg. 2916, effective February 26, 1985; emergency amendment at 9 Ill. Reg. 3825, effective March 13, 1985, for a maximum of 150 days; emergency expired August 10, 1985; amended at 9 Ill. Reg. 6181, effective April 24, 1985; amended at 9 Ill. Reg. 14291, effective September 5, 1985; amended at 10 Ill. Reg. 4835, effective March 6, 1986; amended at 11 Ill. Reg. 4638, effective March 10, 1987; amended at 12 Ill. Reg. 5306, effective March 8, 1988; emergency amendment at 12 Ill. Reg. 6981, effective April 4, 1988, for a maximum of 150 days; emergency expired September 1, 1988; emergency amendment at 12 Ill. Reg. 10525, effective June 7, 1988, for a maximum of 150 days; emergency expired November 4, 1988; amended at 12 Ill. Reg. 15982, effective September 27, 1988; amended at 13 Ill. Reg. 8419, effective May 19, 1989; emergency amendment at 13 Ill. Reg. 12643, effective July 14, 1989, for a maximum of 150 days; emergency expired December 11, 1989; emergency amendment at 13 Ill. Reg. 14085, effective September 4, 1989, for a maximum of 150 days; emergency expired February 1, 1990; emergency amendment at 13 Ill. Reg. 15118,



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effective September 11, 1989, for a maximum of 150 days; emergency expired February 8, 1990; amended at 14 Ill. Reg. 6164, effective April 17, 1990; emergency amendment at 14 Ill. Reg. 6865, effective April 17, 1990, for a maximum of 150 days; emergency expired September 19, 1990; amended at 14 Ill. Reg. 8588, effective May 21, 1990; amended at 14 Ill. Reg. 16863, effective October 1, 1990; amended at 15 Ill. Reg. 4699, effective March 18, 1991; emergency amendment at 15 Ill. Reg. 5430, effective March 27, 1991, for a maximum of 150 days; emergency expired August 24, 1991; amended at 15 Ill. Reg. 9977, effective June 24, 1991; amended at 15 Ill. Reg. 13347, effective September 3, 1991; amended at 16 Ill. Reg. 5267, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 6016, effective March 25, 1992, for a maximum of 150 days; emergency expired August 22, 1992; amended at 16 Ill. Reg. 12526, effective July 28, 1992; amended at 17 Ill. Reg. 3853, effective March 15, 1993; emergency amendment at 17 Ill. Reg. 5915, effective March 25, 1993, for a maximum of 150 days; emergency expired August 22, 1993; amended at 17 Ill. Reg. 10806, effective July 1, 1993; amended at 18 Ill. Reg. 3277, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 5667, effective March 25, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 12652, effective August 9, 1994; amended at 19 Ill. Reg. 2396, effective February 17, 1995; emergency amendment at 19 Ill. Reg. 5262, effective April 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10614, effective July 1, 1995; amended at 20 Ill. Reg. _____, effective _____.

**Section 810.37 Definitions for Site Specific Sportfishing Regulations**

a) Site Specific Regulations are listed by water area affected. The coverage of the regulation is dictated by the extent of the water area listed and not by the county. In some cases, regulations for a given water area or site may extend beyond the county(ies) listed. The county(ies) listed refer to the location of the dam or outfall for impoundments or mouths of small streams. Since large rivers or streams usually flow through many counties, the term "Multiple" is used rather than listing all counties where the large stream or river flows.

b) The subsections listed below are referred to by number in Section 810.45. Each water area listed in Section 810.45 has numbers in parenthesis which explain all of the definitions in this Section which apply to that water area.

1) Anglers must not use more than 2 poles and each pole must not have more than 2 hooks or lures attached while fishing, except that legal size cast nets, (in accordance with subsection 810.50(a)(1)) shad scoops, and minnow seines may be used to obtain shad, minnows, and crayfish to use as bait, provided that they are not sold.

2) Includes white, black, or hybrid crappie, singly or in the aggregate.

3) All largemouth and smallmouth bass taken must be less than 12 inches in total length or greater than 15 inches in total length.

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4) Except that sport fishermen shall be allowed to use trotlines and jugs, and except that the use and aid of underwater breathing devices is prohibited. West of Wolf Creek Road, fishing from boats is permitted all year. Trotlines/jugs must be removed from sunrise until sunset from Memorial Day through Labor Day. East of Wolf Creek Road, fishing from boats is permitted from March 15 through September 30. Fishing from the bank is permitted all year only at the Wolf Creek and Route 148 causeways. On the entire lake, jugs and trotlines must be checked daily and must be removed on the last day they are used. It is illegal to use stakes to anchor any trotlines; they must be anchored only with portable weights and must be removed on the last day they are used. The taking of carp and buffalo with bow and arrow is permissible.
5) Except that sport fishermen may take carp, carpsuckers, buffalo, gar, bowfin and suckers by pitchfork, gigs, bow and arrow or bow and arrow devices.
6) Including the Fox River south of the Illinois-Wisconsin line to the McHenry Dam.
7) Except that sport fishermen may take carp, buffalo, suckers and gar by bow and arrow or bow and arrow devices, gigs or spears during May and June.
8) Daily catch limit includes Striped Bass, White Bass, Yellow Bass and Hybrid Striped Bass either singly or in the aggregate.
9) Catch and Release Fishing Only means that fish (all or identified species) caught must be immediately released alive and in good condition back into the water from which it came.
10) It shall be illegal to process trout during the period of October 1 to 5 a.m. on the third Saturday in October (both dates inclusive) which were taken during that period.
11) It shall be illegal to possess trout during the period of March 15 to 5 a.m. on the 1st Saturday in April (both dates inclusive) which were taken during that period.
12) Daily catch limit for largemouth or smallmouth bass, singly or in the aggregate, shall not exceed 6 fish per day, no more than one of which shall be greater than 15 inches in length and none of which shall be greater than 12 inches and less than or equal to 15 inches in length.
13) Except that jug fishing is permitted from the hours of sunset to sunrise, and except that carp and buffalo may be taken by bow and arrow devices from May 1 through September 30. All jugs must have owner's/user's name and complete address affixed.
14) Daily catch limit includes all fish species (either singly or in the aggregate) caught within each of the following fish groupings.
    A) Largemouth or Smallmouth Bass
    B) Walleye, Sauger, or their hybrid
    C) Bluegill or Redear Sunfish



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15) Daily catch limit includes white, black, or hybrid crappie either singly or in the aggregate.
16) Daily catch limit includes Striped Bass, White Bass and Hybrid Striped Bass either singly or in the aggregate.
17) Daily catch limit shall not exceed 10 fish daily, no more than 3 of which may be 17 inches or longer in length.
18) Except that sport fishermen shall be allowed to use trout lines, jugs and bank poles in the portions of the lake that lie north of the Davenport Bridge and northeast of the Parnell Bridge.
19) No fishing within 250 yards of an occupied waterfowl blind (within the hunting area) on all Department-owned or -managed sites.
20) Carlyle Lake (including its tributary streams and those portions of the Kaskaskia River and Hurricane Creek up the U.S. Army Corps of Engineers Carlyle Lake Project boundaries), U.S. Army Corps of Engineers, Bond, Clinton, and Fayette Counties.
21) Lake Shelbyville (including its tributary streams and those portions of the West Okaw and Kaskaskia Rivers up to Lake Shelbyville Project boundaries), Lake Shelbyville Project Ponds and Woods Lake, U.S. Army Corps of Engineers, Shelby and Moultrie Counties.
22) Rend Lake (including its tributary streams and those portions of the Big Muddy and Casey Fork Rivers up to the Rend Lake Project boundaries), Rend Lake Project Ponds, U.S. Army Corps of Engineers, Franklin and Jefferson Counties.
23) Lake Vermillion and the portion of the North Fork of the Vermillion River between the Lake Vermillion Dam and the Interstate Water Company's Pump Station Spillway, Vermillion County Conservation District, Vermillion County.
24) 10 Fish Daily Creel Limit of which no more than 6 may be walleye.
25) Daily catch limit for largemouth or smallmouth bass, singly or in the aggregate, shall not exceed 3 fish per day, no more than one of which may be equal to or greater than 15 inches in total length and no more than 2 of which may be less than 15 inches in total length.
26) Lake Vermilion - Trot line and jug finishing allowed north of Boiling Springs Road.
27) Except that bank fishing is prohibited. Boat fishing is permitted from the next to last Saturday in April until the second Sunday in October, during the hours of 6:00 a.m. to 10:00 a.m. and 3:00 p.m. to 8:00 p.m.
28) Except that trotlines may be set within 300 feet from shore.
29) Except that carp, buffalo, suckers and carpsuckers may be taken by means of pitchfork and gigs (no bow and arrow devices).
30) Fishing is permitted from March 15 through September 30, both dates inclusive, from sunrise to sunset. Fishing during all other times of the year is illegal and not permitted.
31) Daily catch limit for largemouth or smallmouth bass, singly or in

the aggregate, shall not exceed 3 fish daily, no more than one of which may be equal to or greater than 15 inches in total length and no more than 2 of which may be less than 12 inches in total length.

32) Daily catch limit includes Striped Bass, White Bass, Yellow Bass and Hybrid Striped Bass, either singly or in the aggregate, no more than 4 of which may be 15 inches or longer in length.

33) It shall be unlawful to enter upon a designated waterfowl hunting area during the 7 days prior to the waterfowl season, or to fish on such areas during the regular waterfowl season except in areas posted as open to fishing. It shall be unlawful to enter upon areas designated as waterfowl rest areas or refuges from 2 weeks prior to the start of the regular waterfowl season through the end of waterfowl season.

34) Except that sport fishermen may take carp, buffalo, suckers and gar by bow and arrow or bow and arrow devices, gigs, or spears from May 1 through August 31.

35) Daily catch limit for Walleye, Sauger, or Hybrid Walleye, singly or in the aggregate, shall not exceed 3 fish daily, no more than one of which may be greater than 24 inches in total length and no more than 2 of which may be less than 18 inches in total length and greater than or equal to 14 inches in total length.

36) Except that sportfisherman may not use a minnow seine for bait collecting in Cook County Forest Preserve District Waters (except in the Des Plaines River).

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 810.45 Site Specific Water Area Regulations**

Fishing regulations, including species of fish, fishing methods and daily catch limits are listed for each water area. The numbers in parenthesis refer to the corresponding numbered definitions in Section 810.37 of this Part. If a water area is not listed or if a specific species is not listed, then state-wide restrictions apply. Check the bulletin boards at the specific site for any emergency changes to regulations.

Allison Lake, City of Lincoln
Logan County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Anderson Lake Fish and Wildlife Area (33)
Fulton County

Andover Lake, City of Andover
Henry County



| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Apple River
Jo Daviess County

| | |
|---|---|
| Trout | - Spring Closed Season (11) |

Apple River (within the boundaries of Apple River Canyon State Park)
Jo Daviess County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

Argyle Lake, Argyle Lake State Park
McDonough County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass (14) | - 1 Fish more than 15" and/or 5 less than 12" Daily (12) |
| Trout | - Fall Closed Season (10) |
| Walleye, Sauger or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 10 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 9" Minimum Length Limit |

Ashland City Reservoir, City of Ashland
Cass County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Ashley Reservoir, City of Ashley
Washington County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length |

Auburn Park Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Axehead Lake, Cook County Forest Preserve

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Cook County
All Fish - 2 Pole and Line Fishing Only (1) (36)
Large or Smallmouth Bass - 14" Minimum Length Limit
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Baker Lake, City of Peru
LaSalle County
All Fish - 2 Pole and Line Fishing Only (1)
Bluegill or Redear Sunfish (14) - 10 Fish Daily Creel Limit
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Large or Smallmouth Bass (14) - 1 Fish Daily Creel Limit

Baldwin Lake, Baldwin Lake Conservation Area
Randolph County
All Fish - 2 Pole and Line Fishing Only (1)(5)
Large or Smallmouth Bass - 18" Minimum Length Limit
Striped, White, or Hybrid
Striped Bass - 17" Minimum Length Limit
Striped, White, or Hybrid
Striped Bass (16) - 3 Fish Daily Creel Limit
White, Black, or Hybrid
Crappie (15) - 25 Fish Daily Creel Limit
White, Black, or Hybrid
Crappie - 9" Minimum Length Limit

Banana Lake, Lake County Forest Preserve District
Lake County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass (14) - 1 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Banner Marsh Lake & Ponds, Banner Marsh State Fish and Wildlife Area (33)
Peoria/Fulton Counties
All Fish - 2 Pole and Line Fishing Only (1)(34) ~~(7)~~
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass (14) - 1 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Walleye, Sauger, or Hybrid
Walleye - 14" Minimum Length Limit
White, Black, or Hybrid



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Crappie (15) - 25 Fish Daily Creel Limit
White, Black, or Hybrid
Crappie - 9" Minimum Length Limit

Batchtown Wildlife Management Area (33)
Calhoun County

Baumann Park Lake, City of Cherry Valley
Winnebago County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Large or Smallmouth Bass (14) - 1 Fish Daily Creel Limit

Beall Woods Lake, Beall Woods Conservation Area
Wabash County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Trout - Fall Closed Season (10)

Beaver Dam Lake, Beaver Dam State Park
Macoupin County
All Fish - 2 Pole and Line Fishing Only (1)
Bluegill or Redear Sunfish (14) - 25 Fish Daily Creel Limit
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Large or Smallmouth Bass (14) - 3 Fish Daily Creel Limit
Trout - Fall Closed Season (10)
White, Black, or Hybrid
Crappie (15) - 10 Fish Daily Creel Limit
White, Black, or Hybrid
Crappie - 9" Minimum Length Limit

Beck Lake, Cook County Forest Preserve District
Cook County
All Fish - 2 Pole and Line Fishing Only (1)(36)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Walleye, Sauger, or Hybrid
Walleye - 18" Minimum Length Limit

Belleau Lake, Cook County Forest Preserve District
Cook County
All Fish - 2 Pole and Line Fishing Only ~~(1)~~ (36)
Large or Smallmouth Bass - 14" Minimum Length Limit

| | |
|---|---|
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Bevier Lagoon, Waukegan Park District
Lake County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Bird Park Quarry, City of Kankakee
Kankakee County

| | |
|---|---|
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Bowen Lake, City of Washington
Tazewell County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Borah Lake, City of Olney
Richland County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Boston Pond, Stephen A. Forbes State Park
Marion County

| | |
|---|---|
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Braidwood-Mazonia Lakes and Ponds, Mazonia-Braidwood State Fish and Wildlife Area (33)
Grundy/Will County
(Braidwood Lake is closed to all fishing and boat traffic, except for legal waterfowl hunters, from 2 weeks prior to duck season through the day before duck season and is closed to all fishing during waterfowl season commencing with duck season)

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 10 Fish Daily Creel Limit |



Breeze JC's Park Pond, City of Breeze
Clinton County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Buckner City Reservoir, City of Buckner
Franklin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Bunker Hill Lake, City of Bunker Hill
Macoupin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Burrells Wood Park Pond
White County

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |

Busse Lake, Cook County Forest Preserve
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 18" Minimum Length Limit |

Cache River State Natural Area (19)
Pulaski/Johnson Counties

Calhoun Point Wildlife Management Area (33)
Calhoun County

Calumet River
Cook County

| | |
|---|---|
| Yellow Perch | - 25 Fish Daily Creel Limit |
| Yellow Perch | - Closed During June |

Campbell Pond Wildlife Management Area (19)
Jackson County

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Campus Lake - Southern Illinois University, State of Illlinois
Jackson County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Campus Pond - Eastern Illinois University, State of Illinois
Coles County
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Canton Lake, City of Canton
Fulton County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Large or Smallmouth Bass (16) - 3 Fish Daily Creel Limit

Carlyle Lake , U.S. Army Corps of Engineers (20) (33)
Clinton County
Large or Smallmouth Bass - 14" Minimum Length Limit
Walleye, Sauger, or Hybrid
Walleye - 14" Minimum Length Limit
White, Black, or Hybrid
Crappie (15) - 10 Fish Daily Creel Limit
White, Black, or Hybrid
Crappie - 10" Minimum Length Limit

Carthage Lake, City of Carthage
Hancock County
Channel Catfish - 6 Fish Daily Creel Limit

Cave-in-Rock State Park Pond, Cave-in-Rock State Park
Hardin County
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Cedar Lake, U.S. Forest Service and City of Carbondale
Jackson County (19)
All Fish - 2 Pole and Line Fishing Only (1)
Large or Smallmouth Bass - 14"-18" Protected Slot Length Limit (no possession)
Large or Smallmouth Bass - 2 Fish Under 14" and 2 Fish Over 18" Daily Creel Limit
Striped, White, or Hybrid
Striped Bass - 17" Minimum Length Limit
Striped, White, or Hybrid



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Striped Bass (16) - 3 Fish Daily Creel Limit
Walleye, Sauger, or Hybrid
Walleye - 14" Minimum Length Limit

Centralia Lake , City of Centralia
Marion County
Large or Smallmouth Bass - 15" Minimum Length Limit

Cermack Quarry, Cook County Forest Preserve District
Cook County
All Fish - 2 Pole and Line Fishing Only (1)(36)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit

Champaign Park District Lakes (Kaufman Lake, Heritage Lake, and Mattis Lake), Champaign Park District
Champaign County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Large or Smallmouth
Bass (14) - 1 Fish Daily Creel Limit

Charleston Lower Channel Lake, City of Charleston
Coles County
All Fish - 2 Pole and Line Fishing Only (1)

Charleston Side Channel Lake, City of Charleston
Coles County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Striped, White, or Hybrid
Striped Bass - 17" Minimum Length Limit
Striped, White, or Hybrid
Striped Bass (16) - 3 Fish Daily Creel Limit

Charlie Brown Lake & Pond, City of Flora
Clay County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit

Chauncey Marsh (19)
Lawrence County

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Chicago River (including its North Branch, South Branch, and the North Shore Channel)
Cook County

| | |
|---|---|
| Yellow Perch | - 25 Fish Daily Creel Limit |
| Yellow Perch | - Closed During June |

Citizen's Lake, City of Monmouth
Warren County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Trout | - Fall Closed Season(10) |

Clear Lake, Kickapoo State Park
Vermillion County

| | |
|---|---|
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Clinton Lake, Clinton Lake State Recreation Area (19)
DeWitt County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(18) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |
| Walleye or Sauger | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 15 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 9" Minimum Length Limit |

Coffeen Lake, Coffeen Lake State Fish and Wildlife Area
Montgomery County

| | |
|---|---|
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie (15) | - 10 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 9" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Coles County Airport Lake, Coles County Airport
Coles County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Coleta Trout Pond, State of Illinois
Whiteside County

| | |
|---|---|
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Columbus Park Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Cook Co. F.P.D. Lakes, Cook County Forest Preserve District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Coulterville City Lake, City of Coulterville
Randolph County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Crab Orchard National Wildlife Refuge- Crab Orchard Lake, U.S. Fish and Wildlife Service (19)
Williamson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(4) |
| Striped, White, or Hybrid Striped Bass (16) | - 10 Creel/3 Fish 17" or Longer Daily (17) |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Crab Orchard National Wildlife Refuge- Devil's Kitchen Lake, U.S. Fish and Wildlife Service (19)
Williamson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |

Crab Orchard National Wildlife Refuge- Little Grassy Lake, U.S. Fish and Wildlife Service (19)
Williamson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Crab Orchard National Wildlife Refuge. Refuge Ponds (except Visitor Pond), U.S. Fish and Wildlife Service
Williamson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Crab Orchard National Wildlife Refuge. Visitor Pond, U.S. Fish and Wildlife Service
Williamson County

| | |
|---|---|
| All Fish (30) | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 21" Minimum Length Limit |

Crawford Co. Cons. Area - Picnic Pond, Crawford County Conservation Area
Crawford County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Trout | - Fall Closed Season (10) |

Crawford Co. Cons. Area Ponds, Crawford County Conservation Area
Crawford County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Crull Impoundment Wildlife Management Area (33)
Jersey County

Crystal Lake, Urbana Park District
Champaign County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Dawson Lake & Park Ponds, Moraine View State Park
McLean County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 25 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black or Hybrid Crappie | - 9" Minimum Length Limit |
| White, Black or Hybrid Crappie (15) | - 15 Fish Daily Creel Limit |

Decatur Park Dist. Ponds, City of Decatur
Macon County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |

Defiance Lake, Moraine Hills State Park
McHenry County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Des Plaines River Conservation Area (19)
Will County

Dixon Springs Ag. Center Pond, Dixon Springs Ag. Center
Pope County

| | |
|---|---|
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Dog Island Wildlife Management Area (19)
Pope County

Dolan Lake, Hamilton County Conservation Area
Hamilton County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |

Donnelley State Wildlife Area (33)
Bureau County

Douglas Park Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

DuPage County Forest Preserve District Lakes and Ponds, DuPage County Forest Preserve District
DuPage County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

DuPage River - West Branch (between the dams located in the McDowell Grove Forest Preserve and the Warrenville Grove Forest Preserve)

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

DuPage County
Large or Smallmouth Bass - Catch and Release Fishing Only (9)

East Fork Lake, City of Olney
Richland County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Walleye, Sauger, or Hybrid
Walleye - 14" Minimum Length Limit
White, Black, or Hybrid
Crappie (15) - 25 Fish Daily Creel Limit

Eldon Hazlet State Park (19) (See Also Carlyle Lake)
Clinton County

Elliott Lake, Wheaton Park District
DuPage County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Evergreen Lake, City of Bloomington
McLean County
Large or Smallmouth Bass - 15" Minimum Length Limit
Pure Muskellunge - 35" Minimum Length Limit
Walleye, Sauger, or Hybrid
Walleye - 14" Minimum Length Limit
White, Black, or Hybrid
Crappie (15) - 25 Fish Daily Creel Limit

Faries Park Pond, City of Decatur
Macon County
Trout - Fall Closed Season (10)

Ferne Clyffe Lake, Ferne Clyffe State Park
Johnson County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Flatfoot Lake, Cook County Forest Preserve District
Cook County
All Fish - 2 Pole and Line Fishing Only (1)(36)



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit

Forbes State Lake, Stephen A. Forbes State Park
Marion County
Striped, White, or Hybrid
Striped Bass - 17" Minimum Length Limit
Striped, White, or Hybrid
Striped Bass (16) - 3 Fish Daily Creel Limit
Walleye, Sauger, or Hybrid
Walleye - 14" Minimum Length Limit

Forbes State Park Ponds, Stephen A. Forbes State Park
Marion County
All Fish - 2 Pole and Line Fishing Only (1)(5)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit

Forest Park Lagoon, City of Shelbyville
Shelby County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Fort de Chartres Historic Site (19)
Randolph County

Four Lakes, Winnebego County Forest Preserve
Winnebago County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Fox Chain O'Lakes (including the Fox River south of the Wisconsin-Illinois boundary to the McHenry Dam) (6) (Applies to Grass Lake and Nippersink Lake State Managed Blind Areas Only (19)), State of Illinois
Lake and McHenry Counties
Large or Smallmouth Bass - 14" Minimum Length Limit (6)
Pure Muskellunge - 45" ~~36"~~ Minimum Length Limit
Walleye, Sauger, or Hybrid
Walleye - 14" ~~18"~~ Minimum Length Limit with an 18-24" Protected Slot Length Limit (no possession) (6)
Walleye, Sauger, or Hybrid ~~--3 Fish Daily Creel Limit (6)~~
Walleye (14) - 2 Fish >or=14" and <18" &/or 1 Fish >24" Daily Creel Limit

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

(35)

Fox Ridge State Park (19)
Coles County

Fox River (within the boundaries of Silver Springs State Park)
Kendall County

| | |
|---|---|
| Large or Smallmouth Bass | - 12" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Frank Holten Lakes, Frank Holten State Park
St. Clair County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Franklin Creek (within the boundaries of Franklin Creek State Natural Area)
Lee County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(9) |
| Large or Smallmouth Bass | - 12" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Fuller Lake (19)
Calhoun County

Gale Lake, Village of East Galesburg
Knox County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Garfield Park Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Gabhard Woods Ponds, Gebhard Woods State Park
Grundy County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Trout | - Spring Closed Season (11) |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Giant City Park Ponds, Giant City State Park
Jackson and Union Counties

| | |
|---|---|
| Largemouth and Spotted Bass | - 15" Minimum Length Limit |

Gillespie New City Lake, City of Gillespie
Macoupin County

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Gillespie Old City Lake, City of Gillespie
Macoupin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Glades - 12 Mile Island Wildlife Management Area (33)
Jersey County

Gladstone Lake, Henderson County Conservation Area
Henderson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Glen Oak Park Lagoon, Peoria Park District
Peoria County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Glen Shoals Lake, City of Hillsboro
Montgomery County

| | |
|---|---|
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |

Godar-Diamond/Hurricane Island Wildlife Management Area (33)
Calhoun County

Gompers Park Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Gordon F. More Park Lake, City of Alton | |
| Madison County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 25 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - ~~2 Fish <15" &/or 1 Fish >or= 15" Daily (25)~~ 3 Fish Daily Creel Limit |
| Governor Bond Lake, City of Greenville | |
| Bond County | |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |
| ~~Grayslake Lake,~~ Grayslake Park District (Grayslake and Park Ponds)~~,~~ | |
| Lake County | |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Greenfield City Lake, City of Greenfield | |
| Green County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Greenville Old City Lake, City of Greenville | |
| Bond County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Trout | - Fall Closed Season (10) |
| Harrisburg New City Reservoir, City of Harrisburg | |
| Saline County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Harrisburg Holding Pits North and South, City of Harrisburg | |
| Saline County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Heidecke Lake, Heidecke Lake State Fish and Wildlife Area | |
| Grundy County (33) | |
| (Shall be closed to all fishing and boat traffic except for legal waterfowl hunters from 2 weeks prior to duck season until the close of waterfowl season) | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 18" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 10 Creel/3 Fish 17" or Longer Daily (17) |
| Walleye, Sauger, or Hybrid Walleye | - 22" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye (14) | - 3 Fish Daily Creel Limit |
| Helmbold Slough (19) | |
| Calhoun County | |
| Hennepin Canal-Mainline & Feeder, Hennepin Canal Parkway State Park | |
| Multiple Counties | |
| All Fish | - 2 Pole and Line Fishing Only (1)(13) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| ~~Herrick Lake, DuPage County Forest Preserve District~~ | |
| ~~DuPage County~~ | |
| ~~All Fish~~ | ~~- 2 Pole and Line Fishing Only (1)~~ |
| ~~Channel Catfish~~ | ~~- 6 Fish Daily Creel Limit~~ |
| Hidden Springs State Forest Ponds, Hidden Springs State Forest | |
| Shelby County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - ~~14"~~ 18" Minimum Length Limit |
| Large or Smallmouth Bass | - 1 Fish Daily Creel Limit |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Highland Old City Lake, City of Highland
Madison County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Trout | - Fall Closed Season (10) |

Hillsboro Old City Lake, City of Hillsboro
Montgomery County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |

Homer Lake, Champaign County Forest Preserve District
Champaign County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Hormel Pond, Donnelly State Fish and Wildlife Area
Bureau County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(5) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Horseshoe Lake-Alexander Co., Horseshoe Lake Conservation Area
Alexander County
(Only trolling motors in refuge from October 5-March 1)

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Horseshoe Lake-Madison County, Horseshoe Lake State Park (33)
Madison County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(28) |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| White, Black or Hybrid Crappie (15) | - 25 Fish Daily Creel Limit |

Horton Lake, Nauvoo State Park
Hancock County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Humbolt Park Lagoon, Chicago Park District
Cook County



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Illinois & Michigan Canal, State of Illinois
Grundy/LaSalle/Will Counties

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Illinois Beach State Park Ponds, Illinois Beach State Park
Lake County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Illinois Department of Transportation Lake, State of Illinois
Sangamon County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Illinois River - Pool 26 (19)
Calhoun County

Jackson Park (Columbia Basin) Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Johnson Sauk Trail Lake & Pond, Johnson Sauk Trail State Park
Henry County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Jones Park Lake, City of East St. Louis
St. Clair County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Jones State Lake, Saline County Conservation Area
Saline County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Jones Lake Trout Pond, Saline County Conservation Area

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Saline County
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Jubilee College State Park Ponds, Jubilee College State Park
Peoria County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Large or Smallmouth Bass (14) - 1 Fish Daily Creel Limit

Kankakee River State Park (19)
Kankakee/Will Counties

Kaskaskia River & all tributaries, State of Illinois
Multiple Counties
Walleye, Sauger, or Hybrid Walleye - 14" Minimum Length Limit

Kaskaskia River Fish and Wildlife Area (19)
St. Clair/Randolph/Monroe Counties

Kaskaskia River Fish and Wildlife Area - Doza Creek Wildlife Management Area (33)
St. Clair County

Kendall Co. Lake #1, Kendall County Forest Preserve District
Kendall County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Large or Smallmouth Bass (14) - 3 Fish Daily Creel Limit

Kent Creek
Winnebago County
Trout - Spring Closed Season (11)

Kickapoo State Park Lakes & Ponds, Kickapoo State Park
Vermilion County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Kinkaid Lake, Kinkaid Lake State Fish and Wildlife Area (19)
Jackson County
Large or Smallmouth Bass - 12" - 16" Protected Slot Length Limit (no possession)
Large or Smallmouth Bass - 2 Fish Under 12" and 2 Fish Over 16" Daily Creel Limit
Pure Muskellunge - 45" ~~36"~~ Minimum Length Limit
Walleye, Sauger, or Hybrid Walleye - 14" Minimum Length Limit



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Lake Atwood, McHenry County Conservation District
McHenry County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Trout - Spring Closed Season (11)

Lake Bloomington, City of Bloomington
McLean County
Large or Smallmouth Bass - 15" Minimum Length Limit
Striped, White, or Hybrid Striped Bass - 17" Minimum Length Limit
Striped, White, or Hybrid Striped Bass (16) - 3 Fish Daily Creel Limit
Walleye, Sauger, or Hybrid Walleye - 14" Minimum Length Limit
White, Black, or Hybrid Crappie (15) - 25 Fish Daily Creel Limit

Lake Carlton, Morrison-Rockwood State Park
Whiteside County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass (14) - 1 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Pure Muskellunge - 36" Minimum Length Limit
Walleye, Sauger, or Hybrid Walleye - 14" Minimum Length Limit
White, Black, or Hybrid Crappie (15) - 25 Fish Daily Creel Limit

Lake Co. Forest Preserve District Lakes, Lake County Forest Preserve District
Lake County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large Smallmouth Bass (14) - 1 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit

Lake Decatur, City of Decatur
Macon County
All Fish - 2 Pole and Line Fishing Only (1)
Large or Smallmouth Bass - 14" Minimum Length Limit
Walleye, Sauger, or Hybrid

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Walleye | - 14" Minimum Length Limit |

Lake Depue Fish and Wildlife Area (33)
Bureau County

Lake Eureka, City of Eureka
Woodford County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

Lake George, Loud Thunder Forest Preserve
Rock Island County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Pure Muskellunge | - 36" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 25 Fish Daily Creel Limit |

Lake Jacksonville, City of Jacksonville
Morgan County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 25 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 9" Minimum Length Limit |

Lake Kakusha, City of Mendota
LaSalle County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie (15) | - 10 Fish Daily Creel Limit |

Lake Le-Aqua-Na, Lake Le-Aqua-Na State Park



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Stephenson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 25 Fish Daily Creel Limit |

Lake Mendota, City of Mendota
LaSalle County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass (14) | - 1 Fish >or=15" &/or 2 < 12" Daily (31) |

Lake Michigan (Illinois Portion), State of Illinois
Lake/Cook Counties

| | |
|---|---|
| Trout and Salmon | - 10" Minimum Length Limit |
| Trout and Salmon | - no more than 3 fish of any one species daily, except for Lake Trout |
| Lake Trout | - 2 Fish Daily Creel Limit |
| Yellow Perch | - 25 Fish Daily Creel Limit |
| Yellow Perch | - Closed During June |

Lake Milliken, Des Plaines Conservation Area
Will County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Trout | - Spring Closed Season (11) |

Lake Mingo & Kennekuk Cove Park Ponds, Vermilion County Conservation Area
Vermilion County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 25 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |

Lake Murphysboro, Lake Murphysboro State Park
Jackson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 25 Fish Daily Creel Limit |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |
| ~~Large or Smallmouth Bass~~ | ~~--15" Minimum Length Limit~~ |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Lake Nellie, City of St. Elmo
Fayette County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |

Lake of the Woods & Elk's Pond, Champaign County Forest Preserve District
Champaign County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Trout | - Spring Closed Season (11) |

Lake Olson, Rock Cut State Park
Winnebago County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

Lake Owen, Hazel Crest Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Lake Paradise , City of Mattoon
Coles County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Lake Paradise Shadow Ponds, City of Mattoon
Coles County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Lake Sara, City of Effingham



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Effingham County

| | |
|---|---|
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 25 Fish Daily Creel Limit |

Lake Shelbyville (21), U.S. Army Corps of Engineers
Moultrie/Shelby Counties
(During the regular waterfowl season, no bank or boat fishing shall be permitted on the Kaskaskia River from the Strickland Boat Access north to the Illinois Central Railroad Bridge from one-half hour before sunrise to 1 p.m.)

| | |
|---|---|
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Pure Muskellunge | - 36" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 10 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 10" Minimum Length Limit |

Lake Shelbyville Ponds & Woods Lake, Lake Shelbyville State Fish and Wildlife Area (33)
Moultrie/Shelby Counties

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Lake Sinnissippi (19)
Whiteside County

Lake Springfield, City of Springfield
Sangamon County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 15" minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 25 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 9" Minimum Length Limit |

Lake Storey, City of Galesburg
Knox County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 25 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Walleye, Sauger, or Hydrid | |
| Walleye | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid | |
| Walleye (14) | - 3 Fish Daily Creel Limit |
| **Lake Sule, Flagg-Rochelle Park District** | |
| **Ogle County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear | |
| Sunfish (14) | - 5 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Pure Muskellunge | - 36" Minimum Length Limit |
| Walleye, Sauger, or Hybrid | |
| Walleye | - 14" Minimum Length Limit |
| White, Black or Hybrid | |
| Crappie (15) | - 10 Fish Daily Creel Limit |
| **Lake Taylorville, City of Taylorville** | |
| **Christian County** | |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| White, Black, or Hybrid | |
| Crappie | - 9" Minimum Length Limit |
| White, Black, or Hybrid | |
| Crappie (15) | - 25 Fish Daily Creel Limit |
| **Lake Vandalia, City of Vandalia** | |
| **Fayette County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Striped, White, or Hybrid | |
| Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid | |
| Striped Bass (16) | - 3 Fish Daily Creel Limit |
| **Lake Vermilion, Vermilion County Conservation District** | |
| **Vermilion County** | |
| All Fish | - 2 Pole and Line Fishing Only (26) |
| Large or Smallmouth Bass | - 15" Minimum Length Limit (23) |
| Pure Muskellunge | - 36" Minimum Length Limit (23) |
| Walleye, Sauger, or Hybrid | |
| Walleye | - 14" Minimum Length Limit (23) |
| **Lake Williamsville, City of Williamsville** | |
| **Sangamon County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| **LaSalle Lake, LaSalle Power Station** | |
| **LaSalle County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 18" Minimum Length Limit |
| Striped, White, or Hybrid | |
| Striped Bass (16) | - 10 Creel/3 Fish 17" or Longer Daily (17) |
| **Levings Lake, Rockford Park District** | |
| **Winnebago County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| **Lincoln Log Cabin Pond, Lincoln Log Cabin Historical Site** | |
| **Coles County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| **Lincoln Park North Lagoon, Chicago Park District** | |
| **Cook County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| **Lincoln Park South Lagoon, Chicago Park District** | |
| **Cook County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| **Lincoln Trail Lake, Lincoln Trail State Park** | |
| **Clark County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |
| **Little Black Slough, Little Black Slough State Natural Area** | |
| **Johnson County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| All Fish | - No Seines |
| **Little Sister Lake, County of Fulton** | |
| **Fulton County** | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear | |
| Sunfish (14) | - ~~10~~ 25 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Large or Smallmouth Bass | - ~~15" Minimum Length Limit~~ 12-15" Slot Length Limit (3) |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Lou Yeager Lake, City of Litchfield
Montgomery County

| | |
|---|---|
| Large or Smallmouth Bass | - 15" minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Loami Reservoir, City of Loami
Sangamon County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Lower Cache River, Lower Cache River State Natural Area
Pulaski/Johnson Counties

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| All Fish | - No Seines |

Lyerla Lake, Union County Conservation Area
Union County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Mackinaw River (within the boundaries of Mackinaw River Fish and Wildlife Area)
Tazewell County

| | |
|---|---|
| Large or Smallmouth Bass | - 12" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Macon County Conservation District Ponds, Macon County Conservation District
Macon County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Maple Lake, Cook County Forest Preserve District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(36) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Marquette Park Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |

Marshall County Conservation Area (Fishing Ditch), Marshall County Conservation Area (33)
Marshall County
(Unlawful to trespass upon designated waterfowl hunting areas 7 days prior to the waterfowl season and on areas designated as waterfowl refuges from October 10 until the end of the waterfowl season)

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |

Marshall County Conservation Area - Sparland Unit (19)
Marshall County

Mascoutah Reservoir, City of Mascoutah
St. Clair County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Mattoon Lake, City of Mattoon
Coles County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Mazonia-Braidwood Lakes & Ponds, Mazonia-Braidwood State Fish and Wildlife Area (33)
Grundy/Will Counties
(Braidwood Lake is closed to all fishing and boat traffic from 2 weeks prior to duck season through the day before duck season and is closed to all fishing during waterfowl season commencing with duck season)

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black or Hybrid Crappie (15) | - 10 Fish Daily Creel Limit |

Mautino Fish and Wildlife Area, Mautino Fish and Wildlife Area
Bureau County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

McCullom Lake, City of McHenry
McHenry County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 25 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

McKinley Park Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

McLeansboro City Lakes, City of McLeansboro
Hamilton County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Meredosia Lake - Cass County Portion Only (meandered waters only) (33)
Cass County

Meredosia Lake - Cass County Portion
Cass County
(Meandered waters only) (All boat traffic is prohibited from operating on meandered waters (except non-motorized boats may be used to assist in the retrieval of waterfowl shot from private land) from the period from one week before waterfowl season opens until the season closes; hunting and/or any other activity is prohibited during the period from one week before waterfowl season opens until the season closes)

Mermet State Lake, Mermet Lake Conservation Area (33)
Massac County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Middle Fork Forest Preserve Ponds, Champaign County Forest Preserve
Champaign County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 25 Fish Daily Creel Limit |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Mill Creek Lake, Clark County Park District
Clark County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |
| ~~Walleye, Sauger, or Hybrid~~ Walleye | ~~14" Minimum Length Limit~~ |

Miller Park Lake, City of Bloomington
McLean County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Trout | - Spring Closed Season(11) |

Mineral Springs Park Lagoon, City of Pekin
Tazewell County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Trout | - Fall Closed Season (10) |

Mississippi River Pools 16, 17, 18, 21, 22, 24, 25, 26 (19)
Multiple Counties

Mississippi River (between IL & IA), State of Illinois
Multiple Counties

| | |
|---|---|
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Northern Pike | - 5 Fish Daily Creel Limit |
| Walleye and Sauger (14) | - 10 Fish Daily Creel Limit (24) |
| Walleye | - 15" Minimum Length Limit |

Mississippi River (between IL & MO), State of Illinois
Multiple Counties
(Boating prohibited on refuge area immediately south of Melvin Price Lock and Dam 26 from October 15-April 15)

| | |
|---|---|
| Northern Pike | - 1 Fish Daily Creel Limit |
| Walleye and Sauger (14) | - 8 Fish Daily Creel Limit |

Monee Reservoir, Will County Forest Preserve District
Will County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Montrose Lake, City of Montrose

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Cumberland County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit

Mt. Olive City Lakes, City of Mt. Olive
Macoupin County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Mt. Olive (Old) Lake, City of Mt. Olive
Macoupin County
Large or Smallmouth Bass - 15" Minimum Length Limit

Mt. Sterling Lake, City of Mt. Sterling
Brown County
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 12-15" Slot Length Limit (3)

Mt. Vernon City Park Lake, City of Mt. Vernon
Jefferson County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Mt. Vernon Game Farm Pond, Mt. Vernon Game Farm
Jefferson County
All Fish - 2 Pole and Line Fishing Only (1)
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Mundelein Park Dist. (Diamond Lake & Park Ponds), City of Mundelein
Lake County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Large or Smallmouth Bass (14) - 3 Fish Daily Creel Limit

Nashville City Lake, City of Nashville
Washington County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 18" Minimum Length Limit

Newton Lake, Newton Lake State Fish and Wildlife Area
Jasper County
All Fish - 2 Pole and Line Fishing Only (1)
Large or Smallmouth Bass - 18" Minimum Length Limit
Large or Smallmouth Bass (14) - 3 Fish Daily Creel Limit



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Walleye, Sauger, or Hybrid
Walleye - 14" Minimum Length Limit
White, Black, or Hybrid
Crappie (15) - 10 Fish Daily Creel Limit
White, Black, or Hybrid
Crappie - 10" Minimum Length Limit

Norris City Reservoir, City of Norris City
White County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit

Oakford Conservation Area (Menard County) (19)
Menard County

Oakland City Lake, City Lake, City of Oakland
Coles County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit

Ohio River (between Illinois & Kentucky), State of Illinois
Multiple Counties (19)
Large or Smallmouth Bass - 12" Minimum Length Limit
Northern Pike - No Length or Creel Limit
Muskie or Tiger Muskie - 2 Fish Daily Creel Limit
Walleye, Sauger, or Hybrid
Walleye (14) - 10 Fish Daily Creel Limit
White, Black, or Hybrid
Crappie (15) - 30 Fish Daily Creel Limit
Striped, White, Yellow or Hybrid
Striped Bass - 30 Creel/4 Fish 15" or Longer Daily (32)

Ohio River-Smithland Pool Tributary Streams (in Pope/Hardin/Gallatin Counties, excluding Wabash River and Saline River Above Route 1 Bridge) (19)
Multiple Counties
Large and Smallmouth Bass - 12" Minimum Length Limit

Otter Lake, Otter Lake Water Commission
Macoupin County
Large or Smallmouth Bass - 15" Minimum Length Limit
Large or Smallmouth
Bass (14) - 3 Fish Daily Creel Limit
Striped, White, or Hybrid

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |
| Pure Muskellunge | - ~~36"~~ 45" Minimum Length Limit |

Palmyra City Lake & Terry Park Pond, City of Palmyra
Macoupin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Pana Lake, City of Pana
Shelby and Christian Counties

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Paris East & West Lakes, City of Paris
Edgar County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Peabody River King, Pit #3 Lakes and Ponds, River King State Conservation Area
St. Clair County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie (15) | - 25 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 9" Minimum Length Limit |

~~Peelman Lake, Kickapoo State Park~~
~~Vermilion County~~

| | |
|---|---|
| ~~Large or Smallmouth Bass~~ | ~~- 14" Minimum Length Limit~~ |

Pekin Lake (19)
Tazewell County

Piasa (19)
Madison/Jersey Counties

Pierce Lake, Rock Cut State Park
Winnebago County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(7) |
| Bluegill or Redear Sunfish (14) | - 5 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Pure Muskellunge | - 36" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 25 Fish Daily Creel Limit |

Pike County Conservation Area (19)
Pike County

Pickneyville Lake, City of Pickneyville
Perry County

| | |
|---|---|
| Large or Smallmouth Bass | - 18" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

Pine Creek
Ogle County

| | |
|---|---|
| Trout | - Spring Closed Season (11) |

Pine Creek (within the boundaries of White Pines Forest State Park)
Ogle County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Large or Smallmouth Bass | - 12" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Trout | - Spring Closed Season (11) |

Piscasaw Creek
McHenry County

| | |
|---|---|
| Trout | - 9" Minimum Length Limit |
| Trout | - Spring Closed Season (11) |

Pittsfield City Lake, City of Pittsfield
Pike County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(7) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |

Pocahontas Park Pond, City of Pocahontas
Bond County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |

Powerton Lake, Powerton Lake Fish and Wildlife Area (33)
Tazewell County
(Shall be closed to ~~all fishing and~~ boat traffic except for legal waterfowl hunters from 2 weeks prior to duck season until the close of waterfowl season)

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 18" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Striped, White, or Hybrid<br>Striped Bass (16) | - 10 Creel/3 Fish 17" or Longer Daily (17) |
| Walleye, Sauger, or Hybrid<br>Walleye (14) | - 1 Fish Daily Creel Limit |
| Walleye, Sauger, or Hybrid<br>Walleye | - 24" Minimum Length Limit |

~~Pratt-Wayne-Woods-Lakes,-DuPage-County-Forest-Preserve~~
~~DuPage-County~~

| | |
|---|---|
| ~~All-Fish~~ | ~~--2-Pole-and-Line-Fishing-Only-(1)~~ |
| ~~Channel-Catfish~~ | ~~--6-Fish-Daily-Creel-Limit~~ |

Prospect Pond, City of Moline
Rock Island County

| | |
|---|---|
| Trout | - Fall Closed Season (10) |

Pyramid State Park Lakes & Ponds, Pyramid State Park
Perry County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Ramsey Lake, Ramsey Lake State Park
Fayette County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 25 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid<br>Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid<br>Crappie (15) | - 10 Fish Daily Creel Limit |
| White, Black, or Hybrid<br>Crappie | - 9" Minimum Length Limit |

Randolph County Lake, Randolph County Conservation Area
Randolph County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Trout | - Fall Closed Season (10) |
| Walleye, Sauger, or Hybrid<br>Walleye | - 14" Minimum Length Limit |

Red Hills Lake, Red Hills State Park
Lawrence County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Red's Landing Wildlife Management Area (19)
Calhoun County
(Walk-in area closed to trespassing 7 days prior to duck season)

Redwing Slough/Deer Lake (33)
Lake County

Rend Lake, U.S. Army Corps of Engineers (22) (33)
Franklin County

| | |
|---|---|
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Striped, White, Yellow, or Hybrid<br>Striped Bass (8) | - 10 Creel/3 Fish 17" or Longer Daily (17) |

Rend Lake Project Pond, U.S. Army Corps of Engineers
Franklin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Rice Lake Fish and Wildlife Area (33)
Fulton County

Ridge Lake, Fox Ridge State Park
Coles County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 14" Minimum Length Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid<br>Walleye | - 14" Minimum Length Limit |

Riis Park Lagoon, Chicago Park District

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Cook County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Riprap Landing (19)
Calhoun County

Riverside Park Lagoon, Moline Park District
Rock Island County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Rock Creek, State of Illinois
Kankakee County
Trout - Spring Closed Season (11)

Rock River Main Stem Only (except reach from Oregon Dam to State Route 2 highway bridge at Grand Detour)
Multiple Counties
Large or Smallmouth Bass - 12" Minimum Length Limit
Large or Smallmouth Bass (14) - 3 Fish Daily Creel Limit
Walleye, Sauger, and Hybrid Walleye - 14" Minimum Length Limit

Rock River Main Stem Only (from Oregon Dam to State Route 2 Highway Bridge at Grand Detour)
Ogle County
Large or Smallmouth Bass - Catch and Release Fishing Only (9)
Walleye, Sauger, and Hybrid Walleye - 14" Minimum Length Limit

Rock Springs Pond, Macon County Conservation District
Macon County
Trout - Spring Closed Season (11)

Roodhouse Park Lake, City of Roodhouse
Green County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

St. Elmo South Lake, City of St. Elmo
Fayette County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Sam Dale Lake , Sam Dale Conservation Area
Wayne County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Walleye, Sauger and Hybrid Walleye - 14" Minimum Length Limit

Sam Dale Trout Pond, Sam Dale Conservation Area
Wayne County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 14" Minimum Length Limit
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Sam Parr Lake, Sam Parr State Park
Jasper County
All Fish - 2 Pole and Line Fishing Only (1)
Channel Catfish - 6 Fish Daily Creel Limit

Sand Lake, Illinois Beach State Park
Lake County
Channel Catfish - 6 Fish Daily Creel Limit
Large or Smallmouth Bass - 15" Minimum Length Limit
Large or Smallmouth Bass (14) - 1 Fish Daily Creel Limit
Trout - Fall Closed Season (10)
Trout - Spring Closed Season (11)

Sanganois Conservation Area (33)
Mason/Cass/Schuyler/Menard Counties

Sangchris Lake, Sangchris Lake State Park
Christian/Sangamon Counties
(Posted waterfowl refuge closed to all boat traffic during waterfowl season. Bank fishing along the dam shall be permitted. Fishing shall be prohibited in the east and west arms of the lake during the period from 10 days prior to the duck season through the end of the duck season. Fishing shall be prohibited in the west arm of the lake and the east arm of the lake south of the power lines during that portion of the goose season that follows the duck season)
All Fish - 2 Pole and Line Fishing Only (1)
Large or Smallmouth Bass (14) - 2 Fish <15" &/or 1 Fish >or=15" Daily (25)
White, Black, or Hybrid Crappie (15) - 25 Fish Daily Creel Limit
White, Black, or Hybrid Crappie - 9" Minimum Length Limit

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

Sangchris Lake Park Ponds, Sangchris Lake State Park
Sangamon County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |

Schiller Pond, Cook County Forest Preserve District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) (36) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Schuy-Rush Lake, City of Rushville
Schuyler County

| | |
|---|---|
| Walleye, Sauger, or Hybrid | |
| Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid | |
| Crappie | - 9" Minimum Length Limit |

Senior Citizen's Pond, Kankakee River State Park
Kankakee County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Shabbona Lake, Shabbona Lake State Park
DeKalb County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Pure Muskellunge | - 36" Minimum Length Limit |
| Walleye, Sauger, or Hybrid | |
| Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid | |
| Crappie (15) | - 10 Fish Daily Creel Limit |

Shawnee National Forest Lakes & Ponds less than 10 acres, U.S. Forest Service
Multiple Counties

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |

Shawnee National Forest - Bay Creek Lake #5 and #8 (Sugar Creek Lake), U.S. Forest Service
Pope County



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth and Spotted Bass | - 15" Minimum Length Limit |

Shawnee National Forest - Dutchman Lake, U.S. Forest Service
Johnson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |

Shawnee National Forest - Lake Glendale, U.S. Forest Service
Pope County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |

Shawnee National Forest - Little Cache #1, U.S. Forest Service
Johnson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |

Shawnee National Forest - Little Cedar Lake, U.S. Forest Service
Jackson County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |

Shawnee National Forest - One Horse Gap Lake, U.S. Forest Service
Pope County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |

Shawnee National Forest - Pounds Hollow Lake, U.S. Forest Service
Gallatin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |

Shawnee National Forest - Tecumseh Lake, U.S. Forest Service

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Hardin County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |
| Shawnee National Forest - Turkey Bayou, U.S. Forest Service | |
| Jackson County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |
| Shawnee National Forest - Whoopie Cat Lake, U.S. Forest Service | |
| Hardin County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Largemouth, Smallmouth or Spotted Bass | - 15" Minimum Length Limit |
| Sherman Park Lagoon, Chicago Park District | |
| Cook County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Siloam Springs Lake, Siloam Springs State Park | |
| Adams County | |
| All Fish | - 2 Pole and Line Fishing Only (1) (7) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |
| Silver Lake, DuPage County Forest Preserve District | |
| DuPage County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Larger or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Trout | - Spring Closed Season (11) |
| Silver Lake (Highland), City of Highland | |
| Madison County | |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Silver Springs S.P. (Big Lake) & Ponds, Silver Springs State Park | |
| Kendall County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |
| Site M Ponds #1, #2, #3, and #4, Site M Conservation Area | |
| Cass County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Skokie Lagoons, Cook County Forest Preserve District | |
| Cook County | |
| All Fish | - 2 Pole and Line Fishing Only (1) (36) |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye | - 18" Minimum Length Limit |
| Snake Den Hollow Lakes, Snake Den Hollow State Fish and Wildlife Area | |
| Knox County | |
| (All use other than waterfowl hunting prohibited from October 1 through the end of the goose season) | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 10 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Pure Muskellunge | - 36" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye (14) | - 3 Fish Daily Creel Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 5 Fish Daily Creel Limit |
| Sparta City Lakes, City of Sparta | |
| Randolph County | |
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Spring Lake, City of Macomb | |
| McDonough County | |
| All Fish | - 2 Pole and Line Fishing Only (1) (5) |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Striped, White, or Hybrid Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |

Spring Lake, Flagg-Rochelle Park District
Ogle County

| | |
|---|---|
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

Spring Lakes (North & South), Spring Lake Conservation Area (33)
Tazewell County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1)(7) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |
| Pure Muskellunge | - ~~36"~~ 45" Minimum Length Limit |
| White, Black, or Hybrid Crappie (15) | - 25 Fish Daily Creel Limit |
| White, Black, or Hybrid Crappie | - 9" Minimum Length Limit |

Starved Rock State Park (19)
LaSalle County

Staunton City Lake, City of Staunton
Macoupin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Stephen A. Forbes State Park (19)
Marion County

Sterling Lake, Lake County Forest Preserve District
Lake County

| | |
|---|---|
| All Fish | - 2 Pole & Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |



DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Pure Muskellunge | - 36" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |

Storm Lake, DeKalb Park District
DeKalb County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Stump Lake Wildlife Management Area (33)
Jersey County

Tampier Lake, Cook County Forest Preserve District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (36) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 18" Minimum Length Limit |

Ten Mile Creek Lakes, Ten Mile Creek State Fish and Wildlife Area
Hamilton/Jefferson Counties (19)
(Areas designated as refuge are closed to all access during the Canada goose season)

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Tilton City Lake, City of Tilton
Vermilion County

| | |
|---|---|
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

Tomahawk Lake, Moraine Hills State Park
McHenry County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Tremont Ponds, Village of Tremont
Tazewell County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

DEPARTMENT OF NATURAL RESOURCES

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

Turner Lake, Chain O'Lakes State Park
Lake County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Tuscola City Lake, City of Tuscola
Douglas County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Union County Conservation Area
Union County
(All fishing and boat traffic prohibited October 15-March 1)

Valley Lake, Wildwood Park District
Lake County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

~~Vandalia Correctional Facility Ponds, State of Illinois~~
~~Fayette County~~

| | |
|---|---|
| ~~All Fish~~ | ~~--2 Pole and Line Fishing Only (1)~~ |
| ~~Channel Catfish~~ | ~~--6 Fish Daily Creel Limit~~ |

Vanhorn Woods Pond, Plainfield Park District
Will County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

Vernor Lake, City of Olney
Richland County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Villa Grove East Lake, City of Villa Grove
Douglas County



DEPARTMENT OF NATURAL RESOURCES

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| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |

Villa Grove West Lake, City of Villa Grove
Douglas County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Trout | - Fall Closed Season (10) |

Virginia City Reservoir, City of Virginia
Cass County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Waddams Creek
Stephenson County

| | |
|---|---|
| Trout | - Spring Closed Season (11) |

Walnut Point Lake, Walnut Point State Fish and Wildlife Area
Douglas County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 12-15" Slot Length Limit (3) |

Walton Park Lake, City of Litchfield
Montgomery County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Warrior Lake, Moraine Hills State Park
McHenry County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Washington County Lake, Washington County Conservation Area
Washington County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Striped, White, or Hybrid | |

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| | |
|---|---|
| Striped Bass | - 17" Minimum Length Limit |
| Striped, White, or Hybrid Striped Bass (16) | - 3 Fish Daily Creel Limit |

Washington Park Lagoon, Chicago Park District
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Washington Park Pond, Springfield Park District
Sangamon County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Trout | - Fall Closed Season (10) |
| Trout | - Spring Closed Season (11) |

Waverly Lake, City of Waverly
Morgan County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |

Weinberg-King Pond, Weinberg-King State Park
Schuyler County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Weldon Springs Lake, Weldon Springs State Park
DeWitt County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 15" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

West Frankfort New City Lake, City of West Frankfort
Franklin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

West Frankfort Old City Lake, City of West Frankfort
Franklin County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

West Salem Reservoir, City of Salem
Edwards County



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| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

White Hall City Lake, City of White Hall
Greene County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |

Wilderness Lake, Moraine Hills State Park
McHenry County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 3 Fish Daily Creel Limit |

Wilderness Pond, Fox Ridge State Park
Coles County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Bluegill or Redear Sunfish (14) | - 5 Fish Daily Creel Limit |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 18" ~~14"~~ Minimum Length Limit |
| Large or Smallmouth Bass (14) | - 1 Fish Daily Creel Limit |

William W. Powers Conservation Area (33)
Cook County

Wolf Lake, William W. Powers Conservation Area (33)
Cook County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Large or Smallmouth Bass | - 14" Minimum Length Limit |
| Walleye, Sauger, or Hybrid Walleye | - 14" Minimum Length Limit |

Woodford Co. Cons. Area (Fishing Ditch), Woodford County (33)
Conservation Area
Woodford County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |

Wyman Lake, City of Sullivan
Moultrie County

| | |
|---|---|
| All Fish | - 2 Pole and Line Fishing Only (1) |
| Channel Catfish | - 6 Fish Daily Creel Limit |
| Trout | - Spring Closed Season (11) |

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Yellow Creek
Stephenson County
Trout - Spring Closed Season (11)

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 810.60 Bullfrogs**

a) Statewide Regulations.
   1) Bullfrogs may be taken by hand, pole and line fishing methods, pitchfork, landing net, bow and arrow or bow and arrow device, spear or gig. A landing net is defined as a hand-held net with no greater than 1.5 inch bar measurement netting, an opening of not greater than 5 feet in diameter, and a handle.
   2) No person shall take bullfrogs by commercial fishing devices including hoop nets, traps, or seines, or by the use of firearms, airguns or gas guns.
   3) The season is June 15 to August 31, both dates inclusive.
   4) The daily limit is 8; the possession limit is 16. Persons taking bullfrogs must have a valid sport fishing license or combination hunting and fishing license.

b) Site Specific Regulations.
   Bullfrogs may be taken in accordance with Statewide Regulations, Section 810.60 (a) above, on waters owned, managed or leased by the Department of Natural Resources ~~Conservation~~.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 810.70 Free Fishing Days**

During the period of June 7, 8, 9, and 10, 1996, ~~9, 10, 11, and 12, 1995~~ it shall be legal for any person to fish in waters wholly or in part within the jurisdiction of the State, including the Illinois portion of Lake Michigan, without possessing a sport fishing license or salmon stamp.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 810.80 Emergency Protective Regulations**

a) Emergency regulations will be utilized to protect the sport fisheries resources of the State under the following criteria:
   1) When data analysis based upon biological surveys demonstrates that one or more fish species in a fishery is likely to suffer severe deleterious effects due to angling pressure without the regulation(s).



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   2) The information upon which the regulation(s) is based was not available prior to the time frame required for normal rulemaking procedures.
   3) The emergency regulation(s) must have the approval of the Chief, Division of Fisheries.

b) The regulation(s) will be posted by painted signs at all lake road entrances, boat launching ramps or other heavily used bank fishing areas at least 14 days prior to the onset of said regulation(s). This will apply to State lakes as well as public lakes operating under the management agreement with the Division of Fisheries.

c) A news release explaining the regulation(s) will be supplied by the Department of Natural Resources ~~Conservation~~ to local media prior to the effective date.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 810.90 Fishing Tournament Permit**

a) A fishing tournament permit from the Department of Natural Resources ~~Conservation~~ is needed if:
   1) Prizes are offered for tagged or marked fish and where any of the waters listed in Section 810.45 are named as a tournament site, or
   2) The fishing event is conducted over a period of more than five (5) days during any calendar year, and prizes with a total value in excess of $1,000 are offered, and where any of the waters listed in Section 810.45 are named as a tournament site.

b) Applications for a permit shall be made in writing to the Department of Natural Resources ~~Conservation~~, Division of Fisheries, at least 60 days prior to the first tournament date.

c) Issuance or denial of a permit shall be based upon the Department of Natural Resources' ~~Conservation's~~ assessment of the capability of the fishery resource to absorb the tournament with minimal impact. In determining whether or not to hold a fishing tournament, the Department will estimate the number of fish of a particular species to be caught in order to evaluate the impact of angling days per acre of water. Items to be considered include:
   1) Species sought;
   2) Biological status of population(s) or species sought. The following parameters will be considered in assessing the biological status or condition of the population of the species sought:
      A) Population density;
      B) Growth rate;
      C) Age structure;
      D) Size structure; and
      E) Recruitment;

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3) Length of tournament;
4) Projected tournament fishing pressure, which is the estimated total number of angling days generated by a tournament;
5) Provisions for obtaining, tagging, holding, handling and/or releasing fish;
6) Safety; and
7) Potential boater-user conflicts.

d) Tagged Fishing Tournament permittees must consult with the Division of Fisheries prior to tagging and/or releasing tagged fish to prevent conflict with Department fish tagging projects.

e) Failure to acquire a permit as referenced in subsection (c) above is a petty offense and will result in denial of future applications for a Tagged Fishing Tournament Permit by that applicant, sponsor or group for a period up to five (5) years.

(Source: Amended at 20 Ill. Reg. _____, effective _____)



STATE BOARD OF EDUCATION

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Public Schools Evaluation, Recognition and Supervision

2) Code Citation: 23 Ill. Adm. Code 1

3) Section Numbers: Proposed Action
1.705 Amendment
1.720 Amendment

4) Statutory Authority: 105 ILCS 5/2-3.6

5) A Complete Description of the Subjects and Issues Involved: These amendments are intended to improve the qualifications of teachers in the middle grades by emphasizing strong subject matter knowledge combined with the professional education needed for understanding and delivering instruction to students in this age group. The proposed rules have been approved by the State Teacher Certification Board, which has recommended them to the State Board of Education.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? The rules do not contain an incorporation by reference under Section 5-75 of the Illinois Administrative Procedure Act.

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking will not create or enlarge a state mandate.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Written comments may be submitted within 45 days of the publication of this notice to:

Sally Vogl
Agency Rules Coordinator
Illinois State Board of Education
100 North First Street
Springfield, Illinois 62777
(217) 782-0541

12) Initial Regulatory Flexibility Analysis: These rules will not affect small businesses.

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

STATE BOARD OF EDUCATION

NOTICE OF PROPOSED AMENDMENTS

The full text of the proposed rule(s) begins on the next page:



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NOTICE OF PROPOSED AMENDMENTS

TITLE 23: EDUCATION AND CULTURAL RESOURCES
SUBTITLE A: EDUCATION
CHAPTER I: STATE BOARD OF EDUCATION
SUBCHAPTER a: PUBLIC SCHOOL RECOGNITION

PART 1
PUBLIC SCHOOLS EVALUATION, RECOGNITION AND SUPERVISION

SUBPART A: SCHOOL ACCREDITATION



SUBPART B: SCHOOL GOVERNANCE



SUBPART C: SCHOOL DISTRICT ADMINISTRATION



SUBPART D: THE INSTRUCTIONAL PROGRAM

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SUBPART E: SUPPORT SERVICES



SUBPART F: STAFF CERTIFICATION REQUIREMENTS



SUBPART G: STAFF QUALIFICATIONS





STATE BOARD OF EDUCATION

NOTICE OF PROPOSED AMENDMENTS



AUTHORITY: Implementing Sections 2-3.25, 2-3.25g, 2-3.43, 2-3.44, 2-3.96, 10-17a, 10-20.14, 10-22.43a, 14C-8, 26-13, 27-12.1, 27-13.1, 27-20.3, 27-20.4, 27-20.5, 27-22, and 27-23.3 and authorized by Section 2-3.6 of the School Code [105 ILCS 5/2-3.25, 2-3.25g (see P.A. 89-3, effective February 27, 1995), 2-3.43, 2-3.44, 2-3.96, 10-17a, 10-20.14, 10-22.43a, 14C-8, 26-13, 27-12.1, 27-13.1, 27-20.3, 27-20.4, 27-20.5, 27-22, 27-23.3, and 2-3.6].

SOURCE: Adopted September 21, 1977; codified at 7 Ill. Reg. 16022; amended at 9 Ill. Reg. 8608, effective May 28, 1985; amended at 9 Ill. Reg. 17766, effective November 5, 1985; emergency amendment at 10 Ill. Reg. 14314, effective August 18, 1986, for a maximum of 150 days; amended at 11 Ill. Reg. 3073, effective February 2, 1987; amended at 12 Ill. Reg 4800, effective February 26, 1988; amended at 14 Ill. Reg. 12457, effective July 24, 1990; amended at 15 Ill. Reg. 2692, effective February 1, 1991; amended at 16 Ill. Reg. 18010, effective November 17, 1992; expedited correction at 17 Ill. Reg. 3553, effective November 17, 1992; amended at 18 Ill. Reg. 1171, effective January 10, 1994; emergency amendment at 19 Ill. Reg. 5137, effective March 17, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 6530, effective May 1, 1995; amended at 19 Ill. Reg. 11813, effective August 4, 1995; amended at 20 Ill. Reg. _____, effective _____.

SUBPART G: STAFF QUALIFICATIONS

**Section 1.705 Minimum Requirements for Teachers**

a) The minimum requirements for teaching at a specific grade level or in a subject area are set forth in this Subpart.
b) Where the requirements in Section 1.730 of this Part are specifically enumerated for teaching a subject they shall supersede the requirements in Section ~~Sections~~ 1.710 of this Part ~~and 1.720~~.
c) Quarter-hour and other credit-hour award systems (e.g., a unit award system) shall be translated into semester hours for purposes of this Subpart.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 1.720 Minimum Requirements for Teachers of Middle ~~Junior--High--and~~**

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**~~Departmentalized Upper Elementary~~ Grades**

The requirements of this Section apply to teachers first employed after September 1, 1973, in departmentalized grades 5 through 8 ("middle-grade teachers"). Teachers first employed in grades 5 through 8 prior to September 1, 1973, or employed in non-departmentalized grades 5 through 8, are subject to the requirements of Section 1.710 of this Part. To qualify as a middle-grade teacher, the teacher must have either completed the coursework identified in subsection (a) of this Section prior to July 1, 1997, or completed the coursework identified in subsection (b) of this Section. In some subject matter areas there is specific coursework which must be included among the 18 semester hours to be earned. These requirements are set forth under the relevent subject matter heading in Section 1.730 of this Part.

a) 18 semester hours in the subject matter area of major teaching assignment (e.g., language arts, mathematics, general science, social science, music). ~~, including at least 5 semester hours in each course where subject matter areas are divided into two or more specific courses. This requirement also applies to teachers of the 6th, 7th, and/or 8th grade where the organizational pattern is a junior high or the instructional pattern is in part or entirely departmentalized. When departmentalized in part, the requirement only applies to the departmentalized teachers.~~ Where a teacher is assigned to deliver instruction in two areas (e.g., English and social science or mathematics and science), the teacher shall meet the requirements of this subsection for one area and have no fewer than 5 semester hours in the other instructional area.

~~b) All teachers (except those employed prior to September 1, 1973) assigned departmentalized responsibility shall meet the 18 semester hour requirement. This regulation applies only to the subject area which comprises more than 50% of the instructional periods assigned to a teacher.~~

~~c) In some subject matter areas there is specific coursework which must be included among the 18 semester hours to be earned. These requirements are set forth under the relevant subject matter heading in Section 1.730 of this Part and supersede those contained in subsection (a) above.~~

b) 18 semester hours in the subject matter area of major teaching assignment (e.g., language arts, mathemathics, general science, social science, music). Where a middle-grade teacher is assigned to deliver instruction in two areas (e.g., English and social science or mathematics and science), the teacher shall meet the requirements of this subsection for one area and have no fewer than 9 semester hours in the other instructional area. In addition:

1) 3 semester hours of coursework, offered within a college of education, that the offering institution certifies includes middle-grade philosophy, middle-grade curriculum and instruction, and instructional methods for designing and teaching developmentally appropriate programs (i.e., addressing the



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cognitive, emotional and physical development of each child) in the middle grades, including content area (e.g., science, social science) reading instruction.

2) 3 semester hours of coursework, offered within a college of education, that the offering institution certifies includes educational psychology focusing on the developmental characteristics of early adolescents, the nature and needs of early adolescents, and the role of the middle-grade teacher in assessment, coordination and referral of students to health and social services.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Consumer Installment Loan Act

2) Code Citation: 38 Ill. Adm. Code 110

3) Section Numbers: Proposed Action:

110.190 Amendment

4) Statutory Authority: 205 ILCS 670/22

5) A Complete Description of the Subjects and Issues Involved: The proposed amendment deletes language restricting Consumer Installment Loan Act licensees from offering inducements to encourage people to become borrowers. The amendment deletes the language in order to conform to statutory language that now allows inducements.

6) Will this Proposed Rule Replace an Emergency Rule Currently in effect: No

7) Does this rulemaking contain an automatic repeal date: No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other amendments pending on this part? No

10) Statement of Statewide Policy Objectives: The objective is to amend the rules to conform to the statute and eliminate confusion among licensees. The rules do not require local governments to spend additional revenues.

11) Time Place and Manner in which Interested Parties may Comment on this proposed Rulemaking:

M. Rose Kelly
Chief Counsel
Illinois Department of Financial Institutions
100 W. Randolph, 15th Floor
Chicago, IL 60601
(312) 814-2008

12) Initial Regulatory Flexibility Analysis:

A) Date Rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: November 1, 1995

B) Types of Small Businesses Affected: Licensees

C) Reporting, Bookkeeping or other Procedures required for compliance: None



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D) Types of Professional Skills Necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Amendment begins on the next page.

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NOTICE OF PROPOSED AMENDMENT

TITLE 38: FINANCIAL INSTITUTIONS
CHAPTER I: DEPARTMENT OF FINANCIAL INSTITUTIONS

PART 110
CONSUMER INSTALLMENT LOAN ACT

Section


AUTHORITY: Implementing and authorized by Section 22 of the Consumer Installment Loan Act [205 ILCS 670/22].

SOURCE: Filed and effective June 19, 1970; amended at 3 Ill. Reg. 24, p. 16, effective June 15, 1979; emergency amendment at 4 Ill. Reg. 5, p. 372, effective January 16, 1980, for a maximum of 150 days; amended at 4 Ill. Reg. 36, p. 138, effective September 22, 1980; amended at 5 Ill. Reg. 1352, effective February 3, 1981; codified at 7 Ill. Reg. 11721; amended at 9 Ill. Reg. 1343, effective January 17, 1985; amended at 11 Ill. Reg. 2749, effective January 28, 1987; emergency amendment at 11 Ill. Reg. 14141, effective August



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7, 1987, for a maximum of 150 days; amended at 12 Ill. Reg. 10456, effective June 7, 1988; amended at 19 Ill. Reg. 44, effective December 22, 1994; amended at 20 Ill. Reg. _____, effective _____.

**Section 110.190 Advertising**

a) Licensees shall not advertise "No co-makers required", "No endorsers required", "Signature only" loans, "Loans made on your plain note" or the like, unless such loans constitute at least 50% of all loans made by the licensee.

b) Licensees shall not make reference in any form of advertising such as newspapers, circulars, letters, radio, or other media, to "Low rates", or "Lower rates", or "Lowest rates", or "Lowest cost", or to indicate by direct or indirect means through such expression as "Low cost", "Lower cost", or "Easier to repay", or by any device that the charges for a loan are low.

c) Licensees may advertise "New reduced rates" or "Reduced rates", or similar phrases for not more than sixty days after the effective date of such reduction in rates.

d) Upon specific request by the Department, licensees shall forward to the Supervisor of the Consumer Credit Division the complete text of all advertising copy whether printed or broadcast for which questions have been raised concerning compliance with Section 18 of the Consumer Installment Loan Act.

e) A licensee may indicate in advertising and otherwise that its business is "regulated" or "examined" or "supervised" or "licensed" by the State of Illinois. A licensee may not advertise in a *false, misleading or deceptive manner* or imply or indicate that the rates or charges for loans made are "approved", "set" or "established" by the state government or any enactment. [205 ILCS 670/18]

f) Should any advertisement by a licensee state the amount of any installment payment, dollar amount of any finance charge or number of installments, or period of repayment, the advertisement shall comply with the provisions of the Consumer Credit Protection Act (15 U.S.C. 1601 et seq.) and the regulations applicable thereto issued by the Federal Reserve Board.

g) Any statement of the payment schedule for a loan in an advertisement must show the proceeds of the loan exclusive of the finance charge and indicate the number and amount of the monthly installments required to pay the loan contract. The total of the installments must be sufficient to pay the total of the proceeds and finance charge for the loan according to the payment schedule. When a payment schedule is used, it must disclose the Annual Percentage Rate for each amount of loan advertised, using that term.

h) If the advertisement includes an offer of insurance, the advertisement must disclose the type of insurance offered and whether or not the installments include the cost thereof.

i) The conduct of business by the licensee at locations other than that

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named in the license is prohibited by 205 ILCS 670/7 ~~Ill. Rev. Stat. 1985, ch. 17, par. 5407~~ and therefore advertising to that effect would be misleading and not in compliance with Section 18 of the Act. No licensee shall state or imply either verbally or in print, that he will make any loan or transact business at any place other than that named in the license.

~~j) No licensee shall, by any representation or device, offer to any customer any monetary inducement or any allowance, or anything of value, directly or indirectly by means of which persons will be encouraged to become borrowers. No licensee shall endeavor to obtain loan recommendations by offering to pay, or by paying, with money or other articles of value or by advertising allowances to any merchant, business organization or other persons.~~

j)~~k)~~ On a finding that an advertisement is false, misleading or deceptive, the Director may issue a cease and desist order.

(Source: Amended at 20 Ill. Reg. _____, effective _____)



DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENT

1) Heading of the part: Illinois Credit Union Act

2) Code Citation: 38 Ill. Adm. Code 190

3) Section Numbers: Proposed Action:

| | |
|---|---|
| 190.140 | Amendment |
| 190.160 | Amendment |

4) Statutory Authority: 205 ILCS 305/8

5) A Complete Description of the Subjects and Issues Involved:

**Section 190.140**

The proposed rule expands the lending limits on real estate loans for all credit unions. The rule will now apply to all loans secured by a lien on real estate, rather than only first mortgage loans. The rule adds requirements setting forth the necessary documentation for all real estate loans.

**Section 190.160**

The proposed rule eliminates real estate loans from this provision. The rule increases the lending limits for all consumer loans.

6) Will this Proposed Rule Replace an Emergency Rule Currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other amendments pending on this Part? No

10) Statement of Statewide Policy Objectives:

The proposed rules will allow credit unions to better serve its membership by providing competitive loans in amounts that conform to today's real estate market. The rules differentiate between real estate and consumer loans by requiring more documentation for real estate loans.

The increased lending limits for consumer loans also allow credit unions to provide a necessary service to their membership. The proposed rules do not require local governments to spend additional revenue.

11) Time Place and Manner in which Interested Parties may Comment on this proposed Rulemaking:

DEPARTMENT OF FINANCIAL INSTITUTIONS

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M. Rose Kelly
Chief Counsel
Illinois Department of Financial Institutions
100 W. Randolph, 15th Floor
Chicago, IL 60601
312/814-2008

12) Initial Regulatory Flexibility Analysis:

A) Date Rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: 11/1/95

B) Types of Small Businesses Affected: Credit Unions

C) Reporting, Bookkeeping or other Procedures required for compliance: None

D) Types of Professional Skills Necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the proposed amendments begins on the next page:



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NOTICE OF PROPOSED AMENDMENT

TITLE 38: FINANCIAL INSTITUTIONS
CHAPTER I: DEPARTMENT OF FINANCIAL INSTITUTIONS

PART 190
ILLINOIS CREDIT UNION ACT

Section


AUTHORITY: Implementing and authorized by the Illinois Credit Union Act [205 ILCS 305].

SOURCE: Adopted at 4 Ill. Reg. 20, p. 17, effective May 7, 1980; amended at 6 Ill. Reg. 11154, effective September 7, 1982; amended and codified at 7 Ill. Reg. 14973, effective October 26, 1983; emergency amendment at 9 Ill. Reg. 14378, effective September 11, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 16231, effective October 10, 1985; amended at 10 Ill. Reg. 14667, effective August 27, 1986; amended at 12 Ill. Reg. 10464, effective June 7, 1988; amended at 12 Ill. Reg. 17383, effective October 24, 1988; amended at 13 Ill. Reg. 15998, effective October 2, 1989; emergency amendment at 16 Ill. Reg. 12781, effective July 29, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 17073, effective October 26, 1992; amended at 19 Ill. Reg. 2826, effective February 24, 1995; amended at 20 Ill. Reg. _____, effective _____.

**Section 190.140 ~~First Mortgage~~ Real Estate Lending**

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a) A Credit Union with total assets greater than $1.0 million may, following a resolution of its Board, make loans secured by a lien on ~~first-mortgage-in~~ real estate, subject to the following procedures:

| Total Assets of a Credit Union | Maximum Amount of Loans Secured by ~~a First Mortgage~~ Real Estate | Aggregate of All First Mortgage Loans Secured by Real Estate ~~Mortgages~~ |
|---|---|---|
| Under $1.0 million | Lending Limits for Consumer Loans | 0% of total assets |
| $1.0 - 2.5 million | $100,000 ~~50,000~~ | 25% of total assets |
| $2.5 - 5.0 million | $150,000 ~~75,000~~ | 30% of total assets |
| $5.0 - 10.0 million | $200,000 ~~100,000~~ | 35% of total assets |
| $10.0 - 30.0 million | $350,000 | 40% of total assets |
| over $30 million | $500,000 | 45% of total assets |
| ~~over $10 million~~ | ~~$200,000~~ | ~~40% of total assets~~ |

b) Credit unions with assets under $1.0 million may make home equity and second mortgage loans subject to the lending limits for consumer loans set forth in 38 Ill. Adm. Code 190.160. Credit Unions with assets under $1.0 million shall not make first mortgage real estate loans.

c) Credit unions shall not make first mortgage real estate loans for more than the estimated market value or appraised value of the real estate securing the loans. Real estate loans, other than first mortgage loans, shall be limited to the value of the member-borrower's equity in the real estate securing the loan.

d)~~b~~ ~~Provided--however,--that-the~~ The maximum individual lending limit and the maximum ratio of first mortgage real estate loans may be increased by obtaining written approval from the Director. Such approval is to be based upon the need of the members and the credit union's real estate lending record.

e)~~c~~ The maximum limit on an individual loan by credit unions with assets greater than $1.0 million is in addition to the secured and unsecured lending limits of Section 190.160 of this Part; provided, however, in no event shall all loans to any member exceed in the aggregate 10% of the credit union's unimpaired capital and surplus.

f)~~d~~ The maximum maturity of a loan secured by a first mortgage shall not exceed 30 years.

g)~~e~~ Procedures ~~and-Documentation~~

1) All loans secured by a lien on ~~first-mortgage-in~~ real estate shall be made based upon prudent written lending policies ~~criteria~~ and sound lending practices as documented in each member's loan file. Unless waived by the Director, lending



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policies shall include, without limitation, acceptable debt-to-income and loan-to-value ratios that will be considered the types of real estate security that will be accepted and any other prudent data considered necessary to determine the appropriateness of a loan request. All applicable State and Federal statutes shall be observed.

2) All accounting for real estate loan transactions shall be in accordance with generally accepted accounting principles.

h) Documentation

1) Any credit union granting loans secured by a lien in real estate must procure and retain the following documentation in its files:

A) A loan application that specifies the purpose of the loan (equity, purchase, construction, refinance, etc.). The application must contain sufficient information to support the approval of the loan. Such information shall include without limitation: the amount of the loan requested; the purchase price (if applicable); a listing of the borrower's assets and liabilities; a statement of the borrower's income; a specific identification of the property; and an explanation of the source of the borrower's down payment. If the loan proceeds will be used for the purchase of the property, a copy of the real estate sale contract shall be included as an attachment to the application.

B) A legal opinion from the credit union's attorney, or a title insurance policy that identifies the credit union's lien position on the property used to secure the loan. In the case of home equity lines of credit and second mortgages, a title search prepared by a service provider capable of conducting such a search shall be acceptable.

C) For transactions of $100,000 or less, a written estimate of market value of the property securing the loan, performed by an individual having no direct or indirect interest in the property and experienced to perform such estimations of value for the type and amount of credit being considered. For transactions over $100,000, an appraisal by a state certified or licensed appraiser which estimates the market value of the property used as security for the loan.

D) A credit report prepared by the credit union or a credit reporting agency. The report, in conjunction with the information contained in subsection (h)(1)(A) above, must demonstrate the applicant's past history of repayment and ability to repay the loan in question.

E) A duly executed note and mortgage agreement that outline the borrower's agreement to repay the loan on the terms agreed, and the borrower's agreement to provide the credit union with a valid security interest in the subject property. The mortgage agreement must contain an accurate legal description of the subject property and be duly recorded in

the office of the appropriate county recorder of deeds.

F) A settlement statement reflecting all costs of closing and all disbursements of funds at closing for real estate loans that require the use of a settlement statement under the Real Estate Settlement Procedures Act.

G) On any loan where the lesser of the loan-to-value ratio or loan-to-purchase price ratio exceeds 80%, the credit union may require the borrower to obtain private mortgage insurance insuring the excess of the loan above the 80% factor.

H) In the event the subject loan is to be used for the construction of a residential dwelling that is or will be the principal residence of the member-borrower and the loan will be secured by a perfected first lien or first security interest in favor of the credit union, the credit union must obtain satisfactory evidence of the payment in full of the costs of furnishing labor and material in connection with such construction. Such evidence shall include receipt of an owner's statement, under oath, setting forth the names of all parties with whom the owner has contracted for the furnishing of labor and material; a general contractor's sworn statement from each of the parties named in the owner's statement; a subcontractor's sworn statement from each subcontractor named in the general contractor's statement; and partial and final unconditional lien waivers from the general contractor and all subcontractors and materialmen indicating that they have completed their respective portion of the work and been paid in full. The credit union must inspect, or cause to be inspected by a third party, the completion of each phase of the work for which an advance of any portion of the loan proceeds is sought. Any such inspections must be clearly documented in the file as to the date of the inspection and a brief explanation of the work progression. Additionally, the credit union must obtain a borrower payment authorization, in connection with each payment to the general contractor. This subsection (H) shall not apply to a loan to finance the repair, alteration or improvement of a residential dwelling which is the residence of the member-borrower.

2) A loan secured by a lien on real estate is exempt from the requirements of subsections (h)(1)(B), (C) and (G) of this Section if the loan complies with the following criteria:

A) The loan is not used for the purchase or refinancing of the real estate securing the loan.

B) The lien on real estate is taken as collateral solely through an abundance of caution.

C) The terms of the transaction are not more favorable than they would have been in the absence of the lien on real estate.

D) The transaction complies with the lending limits and other requirements for consumer loans set forth in Section 190.160 of this Part.

i) ~~f)~~ Sale of Real Estate Loans

1) A credit union may sell, in whole or in part, any loan secured by real estate to:

A) Federal National Mortgage Association

B) Government National Mortgage Association

C) Federal Home Loan Mortgage Corporation

D) Federal, State and Local Housing Authorities

E) Federal or State Chartered Banks and Savings and Loan Associations

F) Residential mortgage licensees properly registered with and licensed by the Illinois Commissioner of Savings and Residential Finance

G) Such other institutions as approved by the Director

2) All such sales shall not be subject to recourse or repurchase except for the following:

A) where the repurchase is at the seller's option;

B) where agreement allows substitutions of one loan for another;

C) where an agreement requires repurchase because of breach of warranty or misrepresentation.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 190.160 Lending Limits - Consumer ~~Other Than First Mortgage~~ Loans**

a) The Board of Directors of a credit union shall, for loans other than loans secured by an interest in real estate, establish the maximum lending limits which shall not exceed the limits in the following schedule. A credit union may request approval from the Director for an exception to these limits, which shall be in writing substantiating the need for higher limits, detail the credit union's record of lending activity, and shall include financial statements reflecting sound fiscal history. In no event shall all loans to any member exceed in the aggregate 10% of the credit union's unimpaired capital and surplus.

| Total Credit Union Assets | Maximum Unsecured Limit | Maximum Secured Limit |
|---|---|---|
| $ 0 - $ 50,000 | $750* | $ 5,000* |
| 50,000 - 200,000 | $1,500* | $ 15,000~~7,500~~* |
| 200,000 - 500,000 | $2,500 | $20,000~~10,000~~ |

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| | | | |
|---|---|---|---|
| 500,000 | - 1.0 million | $5,000~~3,500~~ | $25,000~~15,000~~ |
| 1.0 | - 5.0 million | $10,000~~5,000~~ | $40,000~~25,000~~ |
| 5.0 | - 10.0 million | $12,000~~7,500~~ | $50,000~~35,000~~ |
| 10.0 | - 30 million | 15,000 | 65,000 |
| Over | 30 million | 20,000 | 80,000 |
| ~~Over~~ | ~~10.0 million~~ | ~~$10,000~~ | ~~$60,000~~ |

~~*AGENCY NOTE: Per Section 48 of the Illinois Credit Union Act (Ill. Rev. Stat. 1987, ch. 17, par. 4449) the maximum limits will be approved only if these limits are less than or equal to 10% of the credit union's unimpaired capital and surplus.~~

b) The unsecured and secured loan limits are separate limits for each member. Subject to the member aggregate loan limit referenced in subsection (a) above and provided ~~Providing~~ a member is credit worthy, the credit union may lend a total amount equal to the secured and unsecured loan limit to any one member.

c) The above limits may be extended by the amount of the member's unencumbered share account(s) which must be pledged and frozen for the loan amount in excess of the limits.

d) All loans are to be granted based upon prudent lending practice and procedures ~~judgements~~ and in accordance with written lending policies and procedures prescribed by the Board of Directors.

(Source: Amended at 20 Ill. Reg. _____, effective _____)



DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED RULE

1) Heading of the Part: Transmitters of Money Act

2) Code Citation: 38 Ill. Adm. Code 205

3) Section Numbers: Proposed Action:

| | |
|---|---|
| 205.10 | New Section |
| 205.20 | New Section |

4) Statutory Authority: 205 ILCS 657/95

5) A Complete Description of the Subjects and Issues Involved:

**Section 205.10**

The proposed rule sets forth a manner to clarify how to calculate the average daily balance. The rule protects consumers and the integrity of the transmission.

**Section 205.20**

The proposed rule requires licensees to report the removal, addition or termination of an agent's relationship to the licensee.

6) Will this Proposed Rule Replace an Emergency Rule Currently in Effect: No

7) Does this rulemaking contain an automatic repeal date: No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other amendments pending on this part? No

10) Statement of Statewide Policy Objectives: The Transmitters of Money Act does not have any rules or regulations in force at this time. The Department is attempting to provide rules in order to properly regulate its licensees. The proposed rules do not require local governments to spend additional revenues.

11) Time Place and Manner in which Interested Parties may Comment on this Proposed Rulemaking:

M. Rose Kelly
Chief Counsel
Illinois Department of Financial Institutions
100 W. Randolph, 15th Floor
Chicago, IL 60601
(312) 814-2008

12) Initial Regulatory Flexibility Analysis:

DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED RULE

A) Date Rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: November 1, 1995

B) Types of Small Businesses Affected: Transmitter of Money licensees

C) Reporting, Bookkeeping or other Procedures required for compliance: Licensee must report changes in agents on a quarterly basis. Licensee must keep financial records in order.

D) Types of Professional Skills Necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Rule begins on the next page.



DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED RULE

TITLE 38: FINANCIAL INSTITUTIONS
CHAPTER I: DEPARTMENT OF FINANCIAL INSTITUTIONS

PART 205
TRANSMITTERS OF MONEY ACT

Section
205.10 Average Daily Balance
205.20 Authorized Sellers

AUTHORITY: Implementing and authorized by Section 95 of the Transmitters of Money Act [205 ILCS 657/95]

SOURCE: Adopted at 20 Ill. Reg. _____, effective _____.

**Section 205.10 Average Daily Balance**

The average daily balance of payment instruments shall be calculated by averaging the balance of outstanding payment instruments as of the last day of each month for the previous 12 months or operational history, whichever is shorter.

**Section 205.20 Authorized Sellers**

a) A licensee shall report to the Director, on a quarterly basis, the addition, removal or termination of operations of an authorized seller location on forms presented by the Director.
b) This report must be accompanied by $10.00 for each authorized seller added during the respective quarter and sample of the written contract entered into between the licensee and authorized seller.

DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: Uniform Disposition of Unclaimed Property Act

2) Code Citation: 38 Ill. Adm. Code 180

3) Section Numbers: Proposed Action:
180.21 Amendment

4) Statutory Authority: 765 ILCS 1025/26

5) A Complete Description of the Subjects and Issues Involved: The rule requires all holders to remit unclaimed property in U.S. currency.

6) Will this Proposed Rule Replace an Emergency Rule Currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: The Department wants to avoid situations in which holders attempt to pay remittances or examination findings in foreign currency. The rule does not require local governments to spend additional revenues.

11) Time Place and Manner in which Interested Parties may Comment on this proposed Rulemaking:

M. Rose Kelly
Chief Counsel
Illinois Department of Financial Institutions
100 W. Randolph, 15th Floor
Chicago, IL 60601
(312) 814-2008

12) Initial Regulatory Flexibility Analysis:

A) Date Rule was submitted to the Business Assistance Office of the Department of Commerce and Community Affairs: 11/1/95

B) Types of Small Businesses Affected: None

C) Reporting, Bookkeeping or other Procedures required for compliance: None

D) Types of Professional Skills Necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: July 1995



DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENT

The full text of the proposed amendments begins on the next page:

DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENT

TITLE 38: FINANCIAL INSTITUTIONS
CHAPTER I: DEPARTMENT OF FINANCIAL INSTITUTIONS

PART 180
UNIFORM DISPOSITION OF UNCLAIMED PROPERTY ACT

Section


AUTHORITY: Implementing and authorized by Section 26 of the Uniform Disposition of Unclaimed Property Act [765 ILCS 1025/26].

SOURCE: Filed November 20, 1977; emergency amendment at 3 Ill. Reg. 39, p. 225, effective September 14, 1979, for a maximum of 150 days; amended at 3 Ill. Reg. 48, p. 153, effective November 20, 1979; rules repealed, new rules adopted and codified at 8 Ill. Reg. 1464, effective January 18, 1984; amended at 15 Ill. Reg. 8555, effective May 24, 1991; amended at 17 Ill. Reg. 123, effective December 21, 1992; emergency amendment at 17 Ill. Reg. 6321, effective April 6, 1993; amended at 17 Ill. Reg. 9893, effective June 21, 1993; amended at 18 Ill. Reg. 18001, effective December 12, 1994; amended at 20 Ill. Reg. _____, effective _____.

**Section 180.21 Reporting**

a) Reporting Requirements
   1) Business associations who have no reportable property and annual sales of less than $500,000, and whose securities are not publicly traded, whose net worth is less than $1,000,000, and who employ 49 or fewer persons, are not required to file annual reports under Section 11 of the Act.
   2) Business associations who have no reportable property and annual sales of less than $500,000, and whose securities are not publicly traded, whose net worth is less than $1,000,000, and who employ 50 or more people but fewer than 100 persons, are required to file reports in even numbered years on the reporting date specified in Section 11 of the Act.
   3) Notwithstanding the provisions of subsections (a)(1) and (2), a business association must file a report with the Department for all reportable property.

b) Within counties having a total population under 100,000, the County and Municipal Governments and Special Taxing Districts are only required to file a report with the Department for reportable property.

c) In applying Section 10.5(d) of the Act, fraudulent reporting includes, but is not limited to, a determination by a court or administrative hearing that a holder has fraudulently reported or fraudulently failed to remit presumptively abandoned property.

d) In applying Section 10.5(d) of the Act, failure to report includes, but is not limited to, the issuance by the Department of a Notice of Delinquency on a report filed by a holder.

e) A report required to be filed under the Act is deemed received and filed when it has been delivered complete, accurate and in correct form to the Department's Unclaimed Property Division office at 500 Iles Park Place, Suite 500, Springfield, Illinois 62718, and includes any required remittance.

f) A report will be deemed not to be timely received and filed under the Act if it:
   1) is submitted after the required filing date,
   2) is submitted in other than a form authorized in Section 180.22,
   3) is unsigned or undated,
   4) is incomplete, as defined in Section 180.24,
   5) is inaccurate, as defined in Section 180.24,
   6) is without the required remittance, or
   7) does not meet any other requirement under the Act.

g) Reportable property that is not timely reported and remitted by a holder on the first reporting date specified in Section 11 of the Act after the property's initial date of presumptive abandonment must be reported upon discovery of the omission. The holder in the report must identify this property as being reported late and the reason.

h) Any remittance submitted under this Act must be made in United States Currency. Any submission made in foreign currency, money, checks or any other medium of a foreign country is unacceptable.

(Source: Amended at 20 Ill. Reg. _____, effective _____)



DEPARTMENT OF FINANCIAL INSTITUTIONS

NOTICE OF PROPOSED AMENDMENT

DEPARTMENT OF INSURANCE

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Minimum Standards for Individual and Group Medicare Supplement Insurance

2) Code Citation: 50 Ill. Adm. Code 2008

3)

| Section Numbers: | Proposed Action: |
|---|---|
| 2008.10 | Amended |
| 2008.30 | Amended |
| 2008.40 | Amended |
| 2008.50 | Amended |
| 2008.70 | Amended |
| 2008.71 | Amended |
| 2008.73 | Amended |
| 2008.74 | Amended |
| 2008.75 | Amended |
| 2008.80 | Amended |
| 2008.81 | Amended |
| 2008.82 | Amended |
| 2008.90 | Amended |
| 2008.91 | New Section |
| 2008.100 | Amended |
| 2008.101 | Amended |
| 2008.104 | Amended |
| 2008.APPENDIX M | Amended |
| 2008.APPENDIX N | Amended |
| 2008.APPENDIX Q | New Section |

4) Statutory Authority: Implementing Sections 363 and 363a, and authorized by Section 401 of, the Illinois Insurance Code [215 ILCS 5/363, 363a and 401].

5) A Complete Description of the Subjects and Issues Involved:

The Social Security Act Amendments of 1994, (P.L. 103-432, effective October 31, 1994) made a number of changes to the federal requirements for Medicare supplement insurance. On December 1, 1994, Acting Director of Insurance James W. Schacht issued a company bulletin to approximately 70 Medicare supplement insurers which addressed the new federal requirements. This company bulletin is summarized as follows:

A. Open Enrollment - see 42 U.S.C. Sec. 1395ss(s)

The Omnibus Budget Reconciliation Act of 1990 (OBRA 1990) required the issuance of any Medicare supplement policy approved for use in this State to anyone who is age 65 or older for which an application is submitted within 6 months of when the applicant first enrolls in Medicare Part B. Individuals who qualified for Medicare prior to age



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65 and enrolled in Medicare Part B prior to age 65 by reason of disability or end stage renal disease were previously not covered by the OBRA 1990 open enrollment because they were not "first" enrolling in Medicare Part B at age 65.

P.L. 103-432 does not extend open enrollment to persons under age 65 who are eligible for Medicare due to disability or end stage renal disease, however, it does give these individuals a 6-month open enrollment period upon attainment of age 65. Under these provisions, persons are eligible for a 6-month open enrollment period as of the first day they are both 65 years of age or older and enrolled in Medicare Part B. During the open enrollment period, issuers may not deny or condition the issuance or effectiveness of a Medicare supplemental policy, or discriminate in the pricing of the policy because of health status, claims experience, receipt of health care, or medical condition.

Additionally, all Medicare beneficiaries who turned 65 between November 5, 1991, and January 1, 1995, and who were not eligible for the OBRA 1990 open enrollment because they were enrolled in Medicare Part B prior to reaching age 65, are given a one-time 6-month open enrollment period beginning January 1, 1995. This one-time federal open enrollment period applies to any Medicare beneficiary who had Part B coverage prior to age 65 and turned 65 between November 5, 1991, and January 1, 1995.

B. Loss Ratio Provisions - see 42 U.S.C. Sec. 1395ss(r)

Under OBRA 1990, any policy issued after November 5, 1991, was required to obtain a 65% loss ratio for individual policies and a 75% loss ratio for group policies and to return to policyholders premium amounts collected in excess of these standards. Compliance with these requirements is verified through an annual filing of a worksheet showing the experience of those policy forms. However, the effective date of the State requirement was not the same as that of the federal requirement. P.L. 103-432 resolves the difference between the federal effective date and the State effective date on refund calculations and also subjects all Medicare supplement policies to the same loss ratio and refund calculation requirements. However, for policies issued prior to the standardization requirements, the requirements for the 65% loss ratio for individual policies and 75% loss ratio for group policies and refund or credit against future premium payments apply only to the experience occurring after the revised standards are promulgated to implement P.L. 103-432.

C. Duplication of Coverage - see 42 U.S.C. Sec. 1395ss(d)

With the enactment of OBRA 1990, it has generally been a violation of

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federal law to sell or issue a health insurance policy to a Medicare beneficiary with knowledge that the policy duplicates health benefits (Medicare, Medicaid, or private health coverage) to which the individual is otherwise entitled. It is also unlawful for a company to sell a duplicate Medicare supplemental policy to a Medicare beneficiary.

The revised federal law continues the prohibition against selling duplicate Medicare supplemental policies. However, policies which duplicate Medicare will be exempt from the prohibition if they pay benefits directly to the beneficiary without regard to other coverage and the application for insurance contains a clear statement disclosing the extent to which the policies duplicate Medicare. The NAIC had until January 29, 1995, to develop model disclosure statements and submit them to the Secretary of the U. S. Department of Health and Human Services (Secretary) for approval and publication. Policies issued 60 days after publication and approval of the disclosure language which duplicate Medicare must include the approved disclosure statement on the application.

The current prohibition of sales of Medicare supplemental policies to Medicaid beneficiaries has not changed. However, in addition to the existing exception for situations in which Medicaid pays the premium, the revised federal statute allows the sale of a Medicare supplemental policy to a Qualified Medicare Beneficiary (QMB), as defined in 42 U.S.C. Sec. 1396d(p)(1), if the policy provides benefits for prescription drugs. This allows carriers to sell Medicare supplemental standard plans H, I and J to QMBs. QMBs are persons at or below the federal poverty level who also meet certain other resource limits. Additionally, companies may sell a Medicare supplemental policy to a Specified Low-Income Medicare Beneficiary (SLMB). SLMBs are persons at or below 120% of the federal poverty level meeting certain resource limits. Medicaid pays only the Part B premium for SLMBs and covers none of the other cost sharing amounts under Medicare.

D. Agent Compensation - see Section 171(m)(2) of P.L. 103-432

Currently, issuers are prohibited from paying first year commissions in replacement situations unless the benefits are clearly and substantially better than the benefits of the policy being replaced. P.L. 103-432 deletes this exception and prohibits first year commissions on all replacement policies. This change will be effective upon filing these proposed amendments for final adoption.

E. Medicare Select - see Section 172 of P.L. 103-432

The Medicare Select demonstration project has expanded to 50 states



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and the U.S. territories and will continue at least until June 30, 1998.

F. Mailing of Policies - see 42 U.S.C. Sec. 1395ss(d)(4)

OBRA 1990 prohibited issuers from mailing a duplicate copy of a Medicare supplement policy to a policyholder unless the policy had been approved in the state in which the policyholder permanently resides or the policy would terminate within 12 months of being mailed. This affected persons who had misplaced their policy or certificate and had moved to a state where it had not been filed.

P.L. 103-432 permits mailing a duplicate policy which has not been filed in the policyholder's home state under any of the following circumstances:

(1) The policy is guaranteed renewable;
(2) It is a conversion to individual coverage required because the master group policy terminated or the certificate holder has left the group;
(3) A whole group policy is being replaced; or
(4) The individual is reinstating coverage which was suspended during a period of Medicaid eligibility.

6) Will this proposed amendment replace emergency rule currently in effect? No

7) Does this amendment contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: These amendments will not establish, expand or modify the Department's activities in such a way as to necessitate additional expenditures from local revenues.

11) Time, Place, and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to comment on this proposed rulemaking may submit written comments no later than 45 days after the publication of this Notice to:

David VanLieshout
Assistant Chief Counsel
Department of Insurance
320 West Washington
Springfield, IL 62767
(217) 782-2867

(or)

Denise Fuchs
Rules Unit Supervisor
Department of Insurance
320 West Washington
Springfield, IL 62767
(217) 785-8560

DEPARTMENT OF INSURANCE

NOTICE OF PROPOSED AMENDMENTS

12) Initial Regulatory Flexibility Analysis: The Department has determined that the proposed amendments to Section 2008.82 will affect insurance producers. We have notified the major associations for interested parties.

13) Regulatory Agenda on which this amendment was summarized: January 1995

The full text of the Proposed Amendment begins on the next page:



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NOTICE OF PROPOSED AMENDMENTS

TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2008
MINIMUM STANDARDS FOR INDIVIDUAL
AND GROUP MEDICARE SUPPLEMENT INSURANCE

Section

DEPARTMENT OF INSURANCE

NOTICE OF PROPOSED AMENDMENTS

| | |
|---|---|
| APPENDIX I | Plan G |
| APPENDIX J | Plan H |
| APPENDIX K | Plan I |
| APPENDIX L | Plan J |
| APPENDIX M | Notice to Applicant Regarding Replacement of Accident and Sickness Insurance |
| APPENDIX N | Medicare Supplement Refund Calculation Format |
| APPENDIX O | Notice of Medicare Changes |
| APPENDIX P | Medicare Supplement Policies Report |
| APPENDIX Q | Disclosure Statements |

AUTHORITY: Implementing Sections 363 and 363a and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/363, 363a and 401].

SOURCE: Adopted at 6 Ill. Reg. 7115, effective June 1, 1982; adopted at 6 Ill. Reg. 7115, effective January 1, 1983; codified at 7 Ill. Reg. 3474; emergency amendment at 13 Ill. Reg. 586, effective January 1, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 8520, effective May 23, 1989; amended at 14 Ill. Reg. 19243, effective November 27, 1990; amended at 16 Ill. Reg. 2766, effective February 11, 1992; corrected at 16 Ill. Reg. 3590; amended at 16 Ill. Reg 15452, effective September 29, 1992; emergency amendment at 16 Ill. Reg. 19226, effective December 1, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 11469, effective July 9, 1993; amended at 20 Ill. Reg. _____, effective April 28, 1995.

**Section 2008.10 Authority**

This Part is issued by the Director of Insurance pursuant to Section 401 of the Illinois Insurance Code [215 ILCS 5/401] ~~{Ill. Rev. Stat. 1990 Supp., ch. 73, par. 1013}~~ which empowers the Director. . . to *make reasonable rules and regulations as may be necessary for making effective* . . . the insurance laws of this State. This Part implements Sections 363 and 363a of the Illinois Insurance Code [215 ILCS 5/363 and 363a] ~~{Ill. Rev. Stat. 1990 Supp., ch. 73, pars. 975 and 975a, as amended by P.A. 87-0601, effective September 18, 1991}~~.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.30 Applicability and Scope**

a) Except as otherwise specifically provided in Sections 2008.70, 2008.75, 2008.80, ~~and~~ 2008.81, 2008.90 and 2008.103 of this Part shall apply to:
   1) All Medicare supplement policies delivered or issued for delivery in this State on or after the effective date of this Part, ~~hereof~~ and
   2) All certificates issued under group Medicare supplement policies, which policies or contracts have been delivered or issued for delivery in this State.



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b) This Part shall not apply to:
   1) *"Accident Only"* or *"Specified Disease"* types of policies (Section 363(1)(b) of the Illinois Insurance Code (the Code)), or
   2) Policies or health care benefit plans, including group conversion policies, provided to Medicare eligible persons, which policies or plans are not marketed or purported or held to be Medicare supplement policies or benefit plans (Section 363(1)(b) of the Code), or~~.~~
   3) A policy or contract of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or a combination thereof, or for members or former members, or a combination thereof, of the labor organizations.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.40 Definitions**

For the purposes of this Part:

"Applicant" means:
*in the case of an individual Medicare supplement policy, the person who seeks to contract for insurance benefits; and*
*in the case of a group Medicare supplement policy, the proposed certificateholder* (Section 363(2)(a) of the Code).

"Certificate" means *any certificate delivered or issued for delivery in this State under a group Medicare supplement policy* (Section 363(2)(b) of the Code).

"Certificate Form" means the form on which the certificate is delivered or issued for delivery by the issuer.

"Code" means the Illinois Insurance Code [215 ILCS 5] ~~{Ill. Rev. Stat. 1990 Supp., ch. 73, par. 613 et seq.}~~.

"Issuer" includes insurance companies, fraternal benefit societies, health care service plans, and any other entity delivering or issuing for delivery in this State Medicare supplement policies or certificates.

"Medicare" means the "Health Insurance for the Aged Act", Title XVIII of the Social Security Amendments of 1965, as then constituted or later amended.

"Medicare Supplement Policy" means a group or individual policy of [accident and sickness] insurance or a subscriber contract [of

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hospital and medical service associations or health maintenance organizations] other than a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C. Section 1395 et. seq.) or an issued policy under a demonstration project specified in 42 U.S.C. Section 1395ss(g)(1) ~~Accident and Health insurance delivered or issued for delivery in this State by an insurer, fraternal benefit society, nonprofit health, hospital or medical service corporation, prepaid health plan, or any similar organization~~ which is advertised, marketed or designed primarily as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare (Section 363(2)(c) of the Code).

"Policy Form" means the form on which the policy is delivered or issued for delivery by the issuer.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.50 Policy Definitions and Terms**

No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless such policy or certificate contains definitions or terms which conform to the requirements of this Section.

"Accident," "Accidental Injury" or "Accidental Means" shall be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: "Injury or injuries for which benefits are provided means accidental bodily injury sustained by the insured person which is the direct result of an accident ~~cause of loss~~, independent of disease or bodily infirmity or any other cause, and occurs ~~and occurring~~ while the insurance is in force."

Such definition may provide that injuries shall not include injuries for which benefits are provided or available under any workers' compensation, employer's liability or similar law, or motor vehicle no fault plan, unless prohibited by law.

"Benefit Period" or "Medicare Benefit Period" shall not be defined more restrictively than as defined in the Medicare program.

"Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall not be defined more restrictively than as defined in the Medicare program.



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"Duplication of Insurance" means a transaction wherein new accident and health insurance is to be purchased and it is known to the producer or should be known to the producer or the issuer, in the case of a direct response solicitation, that the new insurance will provide some of the benefits or coverages which the proposed insured already has under existing accident and health insurance.

"Health Care Expenses" means expenses of a nonprofit health, hospital or medical service corporation, prepaid health plan or similar organization associated with the delivery of health care services in which providers of the health care services are reimbursed for such services on an other than fee for service basis which are analogous to incurred losses of insurers. Such expenses shall not include:

Home office and overhead costs,
Advertising costs,
Commissions and other acquisition costs,
Taxes,
Capital costs,
Administrative costs, and
Claims processing costs.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals but not more restrictively than as defined in the Medicare program.

"Medicare" shall be defined in the policy and certificate as "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as then constituted ~~Constituted~~ or later amended ~~later Amended~~", or "Title I, Part I of Public Law 89-97, as enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act, as then constituted and any later amendments or substitutes thereof", or words of similar import.

"Medicare Eligible Expenses" shall mean expenses of the kinds covered by Medicare, to the extent recognized as reasonable and medically necessary by Medicare.

"Over-Insurance" means "duplication" of insurance to such extent that the combination of the existing insurance and the proposed insurance would substantially exceed any loss reasonably expected to be incurred.

"Physician" shall not be defined more restrictively than as defined in the Medicare program.

"Sickness" shall not be defined more restrictively than the

following: "Sickness means illness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." The definition may be further modified to exclude sicknesses or diseases for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.70 Minimum Benefit Standards for Policies or Certificates Issued for Delivery Prior to the Effective Date of this Part**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State prior to the effective date of this Part. No policy or certificate may be advertised, solicited or issued for delivery in this State as a Medicare supplement policy or certificate unless it meets or exceeds the following minimum standards. These are minimum standards and do not preclude the inclusion of other provisions or benefits which are not inconsistent with these standards.

a) General Standards.

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate shall not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the effective date of coverage.

2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.

3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.

4) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" Medicare supplement policy shall not:

A) Provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium, or

B) Be cancelled or nonrenewed by the issuer solely on the grounds of deterioration of health.



5) An insurer shall:

A) Except as authorized by the Director of Insurance for this State, an issuer shall neither cancel nor nonrenew a Medicare supplement policy or certificate for any reason other than nonpayment of premium or material misrepresentation.

B) If a group Medicare supplement insurance policy is terminated by the group policyholder and not replaced as provided in subsection (5)(D) below, the issuer shall offer certificateholders an individual Medicare supplement policy. The issuer shall offer the certificateholder at least the following choices:

(i) an individual Medicare supplement policy currently offered by the issuer having comparable benefits to those contained in the terminated group Medicare supplement policy; and

(ii) an individual Medicare supplement policy which provides only such benefits as are required to meet the minimum standards as defined in Section 2008.71(b) of this Part.

C) If a membership in a group is terminated, the issuer shall:

(i) offer the certificateholder such conversion opportunities as are described in subsection (5)(B) above; or

(ii) at the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy.

D) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the ~~succeeding~~ issuer of the replacement policy shall offer coverage to all persons covered under the old group policy on its date of termination. Coverage under the new group policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.

6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be predicated upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or to payment of the maximum benefits.

b) Minimum Benefit Standards.

1) Coverage of Part A Medicare eligible expenses for hospitalization to the extent not covered by Medicare from the 61st day through the 90th day in any Medicare benefit period;

2) Coverage for either all or none of the Medicare Part A inpatient hospital deductible amount;

3) Coverage of Part A Medicare eligible expenses incurred as daily hospital charges during use of Medicare's lifetime hospital inpatient reserve days;
4) Upon exhaustion of all Medicare hospital inpatient coverage including the lifetime reserve days, coverage of ninety percent (90%) of all Medicare Part A eligible expenses for hospitalization not covered by Medicare subject to a lifetime maximum benefit of an additional 365 days;
5) Coverage under Medicare Part A for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations or already paid for under Part B;
6) Coverage for the coinsurance amount of Medicare eligible expenses under Part B regardless of hospital confinement, subject to a maximum calendar year out-of-pocket amount equal to the Medicare Part B deductible [$100];
7) Effective January 1, 1990, coverage under Medicare Part B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) (42 CFR 409.87(a) 1988, no subsequent dates or editions) unless replaced in accordance with federal regulations (42 CFR 409.87(b) 1988, no subsequent dates or editions) or already paid for under Part A, subject to the Medicare deductible amount.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.71 Benefit Standards for Policies or Certificates Issued or Delivered on or After the Effective Date of this Part**

The following standards are applicable to all Medicare supplement policies or certificates delivered or issued for delivery in this State on or after the effective date of this Part. No policy or certificate may be advertised, solicited, delivered or issued for delivery in this State as a Medicare supplement policy or certificate unless it complies with these benefit standards.

a) General Standards

The following standards apply to Medicare supplement policies and certificates and are in addition to all other requirements of this Part.

1) A Medicare supplement policy or certificate shall not exclude or limit benefits for losses incurred more than six (6) months from the effective date of coverage because the losses involved a preexisting condition. The policy or certificate may not define a preexisting condition more restrictively than as a condition for which medical advice was given or treatment was recommended by or received from a physician within six (6) months before the



effective date of coverage.
2) A Medicare supplement policy or certificate shall not indemnify against losses resulting from sickness on a different basis than losses resulting from accidents.
3) A Medicare supplement policy or certificate shall provide that benefits designed to cover cost sharing amounts under Medicare will be changed automatically to coincide with any changes in the applicable Medicare deductible amount and copayment percentage factors. Premiums may be modified to correspond with such changes.
4) No Medicare supplement policy or certificate shall provide for termination of coverage of a spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than the nonpayment of premium.
5) Each Medicare supplement policy shall be guaranteed renewable; and
   A) The issuer shall not cancel or nonrenew the policy solely on the ground of health status of the individual;
   B) The issuer shall not cancel or nonrenew the policy for any reason other than nonpayment of premium or material misrepresentation;
   C) If the Medicare supplement policy is terminated by the group policyholder and is not replaced as provided under Section 2008.71(a)(5)(E), the issuer shall offer certificateholders an individual Medicare supplement policy which (at the option of the certificateholder):
      i) Provides for continuation of the benefits contained in the group policy, or
      ii) Provides for such benefits as otherwise meet the requirements of this subsection;
   D) If an individual is a certificateholder in a group Medicare supplement policy and the individual terminates membership in the group, the issuer shall:
      i) Offer the certificateholder the conversion opportunity described in Section 2008.71(a)(5)(C), or
      ii) At the option of the group policyholder, offer the certificateholder continuation of coverage under the group policy; and
   E) If a group Medicare supplement policy is replaced by another group Medicare supplement policy purchased by the same policyholder, the ~~succeeding~~ issuer of the replacement policy shall offer coverage to all persons covered under the old policy on its date of termination. Coverage under the new policy shall not result in any exclusion for preexisting conditions that would have been covered under the group policy being replaced.
6) Termination of a Medicare supplement policy or certificate shall be without prejudice to any continuous loss which commenced while

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the policy was in force, but the extension of benefits beyond the period during which the policy was in force may be conditioned upon the continuous total disability of the insured, limited to the duration of the policy benefit period, if any, or payment of the maximum benefits.

7) A Medicare supplement policy or certificate shall provide:

A) That benefits and premiums under the policy or certificate shall be suspended at the request of the policyholder or certificateholder for the period (not to exceed twenty-four (24) months) in which the policyholder or certificateholder has applied for and is determined to be entitled to medical assistance under Title XIX of the Social Security Act, but only if the policyholder or certificateholder notifies the issuer of such policy or certificate within ninety (90) days after the date the individual becomes entitled to such assistance. ~~Upon receipt of notice, the issuer shall return to the policyholder or certificateholder that portion of the premium attributable to the period of Medicaid eligibility, subject to adjustment for paid claims.~~

B) If such suspension occurs and if the policyholder or certificateholder loses entitlement to such medical assistance, such policy or certificate shall be automatically reinstituted (effective as of the date of termination of such entitlement) as of the termination of such entitlement if the policyholder or certificateholder provides notice of loss of such entitlement within ninety (90) days after the date of such loss and pays the premium attributable to the period, effective as of the date of termination of such entitlement.

C) Reinstitution of such coverages:

i) Shall not provide for any waiting period with respect to treatment of preexisting conditions;

ii) Shall provide for coverage which is substantially equivalent to coverage in effect before the date of such suspension; and

iii) Shall provide for classification of premiums on terms at least as favorable to the policyholder or certificateholder as the premium classification terms that would have applied to the policyholder or certificateholder had the coverage not been suspended.

b) Standards for Basic ("Core") Benefits Common to All Benefit Plans

Every issuer shall make available a policy or certificate including only the following basic "core" package of benefits to each prospective insured. An issuer may make available to prospective insureds any of the other Medicare Supplement Insurance Benefit Plans in addition to the basic "core" package, but not in lieu thereof.

1) Coverage of Part A Medicare Eligible Expenses for hospitalization to the extent not covered by Medicare from the 61st day through



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the 90th day in any Medicare benefit period;

2) Coverage of Part A Medicare Eligible Expenses incurred for hospitalization to the extent not covered by Medicare for each Medicare lifetime inpatient reserve day used;

3) Upon exhaustion of the Medicare hospital inpatient coverage including the lifetime reserve days, coverage of the Medicare Part A eligible expenses for hospitalization paid at the Diagnostic Related Group (DRG) day outlier per diem or other appropriate standard of payment, subject to a lifetime maximum benefit of an additional 365 days;

4) Coverage under Medicare Parts A and B for the reasonable cost of the first three (3) pints of blood (or equivalent quantities of packed red blood cells, as defined under federal regulations) unless replaced in accordance with federal regulations;

5) Coverage for the coinsurance amount of Medicare Eligible Expenses under Part B regardless of hospital confinement, subject to the Medicare Part B deductible.

c) Standards for Additional Benefits

The following additional benefits shall be included in Medicare Supplement Benefit Plans "B" through "J" only as provided by Section 2008.72 of this Part.

1) Medicare Part A Deductible: Coverage for all of the Medicare Part A inpatient hospital deductible amount per benefit period.

2) Skilled Nursing Facility Care: Coverage for the actual billed charges up to the coinsurance amount from the 21st day through the 100th day in a Medicare benefit period for posthospital skilled nursing facility care eligible under Medicare Part A.

3) Medicare Part B Deductible: Coverage for all of the Medicare Part B deductible amount per calendar year regardless of hospital confinement.

4) Eighty Percent (80%) of the Medicare Part B Excess Charges: Coverage for eighty percent (80%) of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or State law, and the Medicare-approved Part B charge.

5) One Hundred Percent (100%) of the Medicare Part B Excess Charges: Coverage for all of the difference between the actual Medicare Part B charge as billed, not to exceed any charge limitation established by the Medicare program or State law, and the Medicare-approved Part B charge.

6) Basic Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges, after a two hundred fifty dollar ($250) calendar year deductible, to a maximum of one thousand two hundred fifty dollars ($1,250) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

7) Extended Outpatient Prescription Drug Benefit: Coverage for fifty percent (50%) of outpatient prescription drug charges,

after a two hundred fifty dollar ($250) calendar year deductible to a maximum of three thousand dollars ($3,000) in benefits received by the insured per calendar year, to the extent not covered by Medicare.

8) Medically Necessary Emergency Care in a Foreign Country: Coverage to the extent not covered by Medicare for eighty percent (80%) of the billed charges for Medicare-eligible expenses for medically necessary emergency hospital, physician and medical care received in a foreign country, which care would have been covered by Medicare if provided in the United States and which care began during the first sixty (60) consecutive days of each trip outside the United States, subject to a calendar year deductible of two hundred fifty dollars ($250), and a lifetime maximum benefit of fifty thousand dollars ($50,000). For purposes of this benefit, "emergency care" shall mean care needed immediately because of an injury or illness of sudden and unexpected onset.

9) Preventive Medical Care Benefit: Coverage for the following preventive health services:

A) An annual clinical preventive medical history and physical examination that may include tests and services from subsection (B) below and patient education to address preventive health care measures.

B) Any one or a combination of the following preventive screening tests or preventive services, the frequency of which is considered medically appropriate:

i) Fecal occult blood test and/or digital rectal examination;

ii) Mammogram;

iii) Dipstick urinalysis for hematuria, bacteriuria and proteinauria;

iv) Pure tone (air only) hearing screening test, administered or ordered by a physician;

v) Serum cholesterol screening (every five (5) years);

vi) Thyroid function test;

vii) Diabetes screening.

C) Influenza vaccine administered at any appropriate time during the year and Tetanus and Diphtheria booster (every ten (10) years).

D) Any other tests or preventive measures determined appropriate by the attending physician.

E) Reimbursement shall be for the actual charges up to one hundred percent (100%) ~~percent~~ of the Medicare-approved amount for each service, as if Medicare were to cover the service as identified in American Medical Association Current Procedural Terminology (AMA CPT) codes, to a maximum of one hundred twenty dollars ($120) annually under this benefit. This benefit shall not include payment for any



procedure covered by Medicare.

10) At-Home Recovery Benefit: Coverage for services to provide short term, at-home assistance with activities of daily living for those recovering from an illness, injury or surgery.

A) For purposes of this benefit, the following definitions shall apply:

i) "Activities of daily living" include~~,~~ but are not limited to~~,~~ bathing, dressing, personal hygiene, transferring, eating, ambulating, assistance with drugs that are normally self-administered, and changing bandages or other dressings.

ii) "Care provider" means a duly qualified or licensed home health aide/homemaker, personal care aide or nurse provided through a licensed home health care agency or referred by a licensed referral agency or licensed nurses registry.

iii) "Home" shall mean any place used by the insured as a place of residence, provided that such place would qualify as a residence for home health care services covered by Medicare. A hospital or skilled nursing facility shall not be considered the insured's place of residence.

iv) "At-home recovery visit" means the period of a visit required to provide at home recovery care, without limit on the duration of the visit, except each consecutive 4 hours in a 24-hour period of services provided by a care provider is one visit.

B) Coverage Requirements and Limitations

i) At-home recovery services provided must be primarily services which assist in activities of daily living.

ii) The insured's attending physician must certify that the specific type and frequency of at-home recovery services are necessary because of a condition for which a home care plan of treatment was approved by Medicare.

iii) Coverage is limited to:

No more than the number and type of at-home recovery visits certified as necessary by the insured's attending physician. The total number of at-home recovery visits shall not exceed the number of Medicare approved home health care visits under a Medicare approved home care plan of treatment ~~Home Care Plan of Treatment~~.

The actual charges for each visit up to a maximum reimbursement of forty dollars ($40) per visit.

One thousand six hundred dollars ($1,600) per calendar

year.

Seven (7) visits in any one week.

Care furnished on a visiting basis in the insured's home.

Services provided by a care provider as defined in this Section.

At-home recovery visits while the insured is covered under the policy or certificate and not otherwise excluded.

At-home recovery visits received during the period the insured is receiving Medicare approved home care services or no more than eight (8) weeks after the service date of the last Medicare approved home health care visit.

C) Coverage is excluded for:

i) Home care visits paid for by Medicare or other government programs; and

ii) Care provided by family members, unpaid volunteers or providers who are not care providers.

ll) New or Innovative Benefits: An issuer may, with the prior approval of the Director, offer policies or certificates with new or innovative benefits in addition to the benefits provided in a policy or certificate that otherwise complies with the applicable standards. Such new or innovative benefits may include benefits that are appropriate to Medicare supplement insurance, new or innovative, not otherwise available, cost-effective, and offered in a manner which is consistent with the goal of simplification of Medicare supplement policies.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.73 Medicare Select Policies and Certificates**

a) This Section shall apply to Medicare Select policies and certificates, as defined in this Section. No policy or certificate may be advertised as a Medicare Select policy or certificate unless it meets the requirements of this Section.

b) For the purposes of this Section:

1) "Complaint" means any dissatisfaction expressed by an individual concerning a Medicare Select issuer or its network providers.

2) "Grievance" means disatisfaction expressed in writing by an individual insured under a Medicare Select policy or certificate with the administration, claims practices, or provision of





services concerning a Medicare Select issuer or its network providers.

3) "Medicare Select Issuer ~~issuer~~" means an issuer offering, or seeking to offer, a Medicare Select policy or certificate.

4) "Medicare Select Policy ~~policy~~" or "Medicare Select Certificate ~~certificate~~" mean respectively a Medicare supplement policy or certificate that contains restricted network provisions.

5) "Network Provider ~~provider~~" means a provider of health care, or a group of providers of health care, which has entered into a written agreement with the issuer to provide benefits insured under a Medicare Select policy.

6) "Restricted Network Provision ~~network--provision~~" means any provision which conditions the payment of benefits, in whole or in part, on the use of network providers.

7) "Service Area ~~area~~" means the geographic area approved by the Director within which an issuer is authorized to offer a Medicare Select policy.

c) The Director of Insurance may authorize an issuer to offer a Medicare Select policy or certificate, pursuant to this Section and Section 4358 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 if the Director finds that the issuer has satisfied all of the requirements of this Part.

d) A Medicare Select issuer shall not issue a Medicare Select policy or certificate in this State until its plan of operation has been approved by the Director of Insurance.

e) A Medicare Select issuer shall file a proposed plan of operation with the Director of Insurance in a format prescribed by the Director. The plan of operation shall contain at least the following information:

1) Evidence that all covered services that are subject to restricted network provisions are available and accessible through network providers, including a demonstration that:

A) Such services can be provided by network providers with reasonable promptness with respect to geographic location, hours of operation and after-hour care. The hours of operation and availability of after-hour care shall reflect usual practice in the local area. Geographic availability shall reflect the usual travel times within the community.

B) The number of network providers in the service area is sufficient, with respect to current and expected policyholders, either:

i) To deliver adequately all services that are subject to a restricted network provision; or

ii) To make appropriate referrals.

C) There are written agreements with network providers describing specific responsibilities.

D) Emergency care is available twenty-four (24) hours per day and seven (7) days per week.

E) In the case of covered services that are subject to a

restricted network provision and are provided on a prepaid basis, there are written agreements with network providers prohibiting such providers from billing or otherwise seeking reimbursement from or recourse against any individual insured under a Medicare Select policy or certificate. This subsection shall not apply to supplemental charges or coinsurance amounts as stated in the Medicare Select policy or certificate.

2) A statement or map providing a clear description of the service area.

3) A description of the grievance procedure to be utilized.

4) A description of the quality assurance program, including:

A) The formal organizational structure;

B) The written criteria for selection, retention and removal of network providers; and

C) The procedures for evaluating quality of care provided by network providers, and the process to initiate corrective action when warranted.

5) A list and description, by specialty, of the network providers.

6) Copies of the written information proposed to be used by the issuer to comply with subsection (i) below.

7) Any other information requested by the Director of Insurance.

f) A Medicare Select issuer shall:

1) File any proposed changes to the plan of operation, except for changes to the list of network providers, with the Director prior to implementing such changes. Such changes shall be considered approved by the Director after thirty (30) days unless specifically disapproved.

2) An updated list of network providers shall be filed with the Director of Insurance at least quarterly.

g) A Medicare ~~medicare~~ Select policy or certificate shall not restrict payment for covered services provided by non-network providers if:

1) The services are for symptoms requiring emergency care or are immediately required for an unforeseen illness, injury or condition; and

2) It is not reasonable to obtain such services through a network provider.

h) A Medicare Select policy or certificate shall provide payment for full coverage under the policy for covered services that are not available through network providers.

i) A Medicare Select issuer shall make full and fair disclosure in writing of the provisions, restrictions, and limitations of the Medicare Select policy or certificate to each applicant. This disclosure shall include at least the following:

1) An outline of coverage sufficient to permit the applicant to compare the coverage and premiums of the Medicare Select policy or certificate with:

A) Other Medicare supplement policies or certificates offered by the issuer; and

B) Other Medicare Select policies or certificates.

2) A description (including address, phone number and hours of operation) of the network providers, including primary care physicians, specialty physicians, hospitals, and other providers.

3) A description of the restricted network provisions, including payments for coinsurance and deductibles when providers other than network providers are utilized.

4) A description of coverage for emergency and urgently needed care and other out of service area coverage.

5) A description of limitations on referrals to restricted network providers and to other providers.

6) A description of the policyholder's right to purchase any other Medicare supplement policy or certificate otherwise offered by the issuer.

7) A description of the Medicare Select issuer's quality assurance program and grievance procedure.

j) Prior to the sale of a Medicare Select policy or certificate, a Medicare Select issuer shall obtain from the applicant a signed and dated form stating that the applicant has received the information provided pursuant to subsection (i) above and that the applicant understands the restrictions of the Medicare Select policy or certificate.

k) A Medicare Select issuer shall have and use procedures for hearing complaints and resolving written grievances from the subscribers. Such procedures shall be aimed at mutual agreement for settlement and may include arbitration procedures.

1) The grievance procedure shall be described in the policy and certificates and in the outline of coverage.

2) At the time the policy or certificate is issued, the issuer shall provide detailed information to the policyholder describing how a grievance may be registered with the issuer.

3) Grievances shall be considered in a timely manner and shall be transmitted to decision makers who have authority to investigate the issue and take corrective action.

4) If a grievance is found to be valid, corrective action shall be taken promptly.

5) All concerned parties shall be notified about the results of a grievance.

6) The issuer shall report no later than each March 31st to the Director of Insurance regarding its grievance procedure. The report shall be in a format prescribed by the Director and shall contain the number of grievances filed in the past year and a summary of the subject, nature and resolution of such grievances.

l) At the time of initial purchase, a Medicare Select issuer shall make available to each applicant for a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate otherwise offered by the issuer.

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m) At the request of an individual insured under a Medicare Select policy or certificate, a Medicare Select issuer shall make available to the individual insured the opportunity to purchase a Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies or certificates available without requiring evidence of insurability after the Medicare Select ~~supplement~~ policy or certificate has been in force for six (6) months.
   1) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have "comparable or lesser" benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced.
   2) For the purposes of this subsection, a "significant benefit" means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

n) Medicare Select policies and certificates shall provide for continuation of coverage in the event the Secretary of Health and Human Services determines that Medicare Select policies and certificates issued pursuant to this Section should be discontinued due to either the failure of the Medicare Select Program to be reauthorized under law or its substantial amendment.
   1) Each Medicare Select issuer shall make available to each individual insured under a Medicare Select policy or certificate the opportunity to purchase any Medicare supplement policy or certificate offered by the issuer which has comparable or lesser benefits and which does not contain a restricted network provision. The issuer shall make such policies and certificates available without requiring evidence of insurability.
   2) For the purposes of this subsection, a Medicare supplement policy or certificate will be considered to have "comparable or lesser" benefits unless it contains one or more significant benefits not included in the Medicare Select policy or certificate being replaced. For the purposes of this subsection, a "significant benefit" means coverage for the Medicare Part A deductible, coverage for prescription drugs, coverage for at-home recovery services or coverage for Part B excess charges.

o) A Medicare Select issuer shall comply with requests for data made by State or federal agencies, including the United States Department of Health and Human Services, for the purpose of evaluating the Medicare Select Program.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.74 Open Enrollment**



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a) ~~Pursuant to Section 4357 of the Omnibus Budget Reconciliation Act (OBRA) of 1990, the requirements of subsection (a) and (b) are effective November 5, 1991.~~ No issuer shall deny or condition the issuance or effectiveness of any Medicare supplement policy or certificate available for sale in this State, nor discriminate in the pricing of such a policy or certificate because of the health status, claims experience, receipt of health care, or medical condition of an applicant in the case of ~~where~~ an application for a ~~such~~ policy or certificate that is submitted prior to or during the six (6) month period beginning with the first day of the month in which an individual ~~(who~~ is both 65 years of age or older~~) first~~ and is enrolled for benefits under Medicare Part B. Each Medicare supplement policy and certificate ~~certificates~~ currently available from an insurer shall be made available to all applicants who qualify under this subsection without regard to age.

b) Except as otherwise provided in Section 2008.104 of this Part, subsection ~~Subsection~~ (a) shall not be construed as preventing the exclusion of benefits under a policy, during the first six (6) months, based on a preexisting condition for which the policyholder or certificateholder received treatment or was otherwise diagnosed during the six (6) months before the coverage ~~it~~ became effective.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.75 Standards for Claims Payment**

a) An issuer shall comply with Section 1882(c)(3) of the Social Security Act (as enacted by Section 4081(b)(2)(C) of the Omnibus Budget Reconciliation Act of 1987 (OBRA) (P.L. 100-203)) by:
   1) Accepting a notice from a Medicare carrier on dually assigned claims submitted by participating physicians and suppliers as a claim for benefits in place of any other claim form otherwise required and making a payment determination on the basis of the information contained in that notice;
   2) Notifying the participating physician or supplier and the beneficiary of the payment determination;
   3) Paying the participating physician or supplier directly;
   4) Furnishing, at the time of enrollment, each enrollee with a card listing the policy name, number, and a central mailing address to which notices from a Medicare carrier may be sent;
   5) Paying user fees for claim notices that are transmitted electronically or otherwise; and
   6) Providing to the Secretary of Health and Human Services, at least annually, a central mailing address to which all claims may be sent by Medicare carriers.

b) Compliance with the requirements set forth in subsection (a) shall be certified on the Medicare supplement insurance experience reporting form.

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(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.80 Loss Ratio Standards and Refund or Credit of Premium**

a) Loss Ratio Standards ~~Pursuant to Section 4355 of the Omnibus Budget Reconciliation Act (OBRA) of 1990 (P.L. 101-508) and Section 363a of P.A. 87-0601, the requirements of this subsection are effective November 5, 1991.~~

1) A Medicare supplement policy form or certificate form shall not be delivered or issued for delivery unless the policy form or certificate form can be expected, as estimated for the entire period for which rates are computed to provide coverage, to return to policyholders and certificateholders in the form of aggregate benefits (not including anticipated refunds or credits) provided under the policy form or certificate form, calculated on the basis of incurred claims experience or incurred health care expenses where coverage is provided by a health maintenance organization on a service rather than reimbursement basis ~~, as appropriate,~~ and earned premiums for such period and in accordance with accepted actuarial principles and practices:

A) At least 75% of the aggregate amount of premiums earned in the case of group policies; or

B) At least 65% of the aggregate amount of premiums earned in the case of individual policies.

2) All filings of rates and rating schedules shall demonstrate that expected claims in relation to premiums comply with the requirements of this Section when combined with actual experience to date. Filings of rate revisions shall also demonstrate that the anticipated loss ratio over the entire future period for which the revised rates are computed to provide coverage can be expected to meet the appropriate loss ratio standards.

3) For purposes of applying subsection (a) of this Section and Subsection 2008.81(c)(2) of this Part, policies issued as a result of solicitations of individuals through the mails or by mass media advertising (including both print and broadcast advertising) shall be deemed to be individual policies.

4) For policies issued prior to the effective date of this Part, expected claims in relation to premiums shall meet:

A) The originally filed anticipated loss ratio when combined with the actual experience since inception;

B) The appropriate loss ratio requirement from subsections (a)(1)(A) and (B) when combined with actual experience beginning April 28, 1996 to date; and

C) The appropriate loss ratio requirement from subsections (a)(1)(A) and (B) over the entire future period for which the rates are computed to provide coverage.

b) Refund or Credit Calculation

1) An issuer shall collect and file with the Director by May 31 of each year the data contained in Appendix N of this Part for each type in a standard Medicare supplement benefit plan.

2) If, on the basis of the experience as reported, the benchmark ratio since inception (ratio 1) exceeds the adjusted experience ratio since inception (ratio 3), then a refund or credit calculation is required. The refund calculation shall be done on a statewide basis for each type in a standard Medicare supplement benefit plan. For purposes of the refund or credit calculation, experience on policies issued within the reporting year shall be excluded.

3) For the purposes of this Section, for policies or certificates issued prior to November 5, 1991, the issuer shall make the refund or credit calculation separately for all individual policies (including all group policies subject to an individual loss ratio standard when issued) combined and all other group policies combined for experience after April 28, 1996. The first such report shall be due by May 31, 1998.

4) ~~3)~~ A refund or credit shall be made only when the benchmark loss ratio exceeds the adjusted experience loss ratio and the amount to be refunded or credited exceeds a de minimis level. Such refund shall include interest from the end of the calendar year to the date of the refund or credit at a rate specified by the Secretary of Health and Human Services, but in no event shall it be less than the average rate of interest for 13-week Treasury notes. A refund or credit against premiums due shall be made by September 30 following the experience year upon which the refund or credit is based.

c) Annual Filing of Premium Rates

An issuer of Medicare supplement policies and certificates issued in this State before or after the effective date of this Part shall file annually its rates, rating schedule and supporting documentation including ratios of incurred losses to earned premiums by policy duration for approval by the Director in accordance with the filing requirements and procedures prescribed by the Director. The supporting documentation shall also demonstrate, in accordance with actuarial standards of practice using reasonable assumptions, that the appropriate loss ratio standards can be expected to be met over the entire period for which rates are computed. Such demonstration shall exclude active life reserves. An expected third-year loss ratio which is greater than or equal to the applicable percentage shall be demonstrated for policies or certificates in force less than three (3) years.

d) As soon as practicable, but prior to the effective date of enhancements in Medicare benefits, every issuer of Medicare supplement policies or certificates in this State shall file with the Department:

1) Appropriate premium adjustments necessary to produce loss ratios as anticipated for the current premium for the applicable policies or certificates. Such supporting documents as are



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necessary to justify the adjustment shall accompany the filing.

2) An issuer shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or certificate as will conform with minimum loss ratio standards for Medicare supplement policies and which are expected to result in a loss ratio at least as great as that originally anticipated in the rates used to produce current premiums by the issuer for such Medicare supplement policies or certificates. No premium adjustment which would modify the loss ratio experience under the policy other than the adjustments described herein shall be made with respect to a policy at any time other than upon its renewal date or anniversary date.

3) If an issuer fails to make premium adjustments acceptable to the Director, the Director may order premium adjustments, refunds or premium credits deemed necessary to achieve the loss ratio required by this Section.

4) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement policy or certificate modifications necessary to eliminate benefit duplications with Medicare. Such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or certificate.

e) Public Hearings
The Director may conduct a public hearing to gather information concerning a request by an issuer for an increase in a rate for a policy form or certificate form issued before or after the effective date of this Part if the experience of the form for the previous reporting period is not in compliance with the applicable loss ratio standard. The determination of compliance is made without consideration of any refund or credit for such reporting period.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.81 Filing and Approval of Policies and Certificates and Premium Rates**

a) An issuer shall not deliver or issue for delivery a policy or certificate to a resident of this State unless the policy form or certificate form has been filed with and approved by the Director pursuant to 50 Ill. Adm. Code 916.

b) An issuer shall not use or change premium rates for a Medicare supplement policy or certificate unless the rates, rating schedule and supporting documentation have been filed with and approved by the Director pursuant to 50 Ill. Adm. Code 916.

c) Except as provided in subsection (c)(1) below, an issuer shall not file for approval more than one form of a policy or certificate of each type for each standard Medicare supplement benefit plan.

1) An issuer may offer, with the approval of the Director, up to four additional policy forms or certificate forms of the same type for the same standard Medicare supplement benefit plan, one for each of the following cases:

A) The inclusion of new or innovative benefits;

B) The addition of either direct response or producer marketing methods;

C) The addition of either guaranteed issue or underwritten coverage;

D) The offering of coverage to individuals eligible for Medicare by reason of disability.

2) For the purposes of this Section, a "type" means an individual policy, a group policy, an individual Medicare Select policy, or a group Medicare Select policy.

d) Except as provided in subsection (1) below, an issuer shall continue to make available for purchase any policy form or certificate form issued after the effective date of this Part that has been approved by the Director. A policy form or certificate form shall not be considered to be available for purchase unless the issuer has actively offered it for sale in the previous twelve months.

1) An issuer may discontinue the availability of a policy form or certificate form if the issuer provides to the Director in writing its decision at least 30 days prior to discontinuing the availability of the form of the policy or certificate. After receipt of the notice by the Director, the issuer shall no longer offer for sale the policy form or certificate form in this State.

2) An issuer that discontinues the availability of a policy form or certificate form pursuant to subsection (1) above shall not file for approval a new policy form or certificate form of the same type for the same standard Medicare supplement benefit plan as the discontinued form for a period of five years after the issuer provides notice to the Director of the discontinuance. The period of discontinuance may be reduced if the Director determines that a shorter period is appropriate.

3) The sale or other transfer of Medicare supplement business to another issuer shall be considered a discontinuance for the purposes of this subsection.

4) A change in the rating structure or methodology shall be considered a discontinuance under subsections (d)(1) and (2) above unless the issuer complies with the following requirements:

A) The issuer provides an actuarial memorandum, in a form and manner prescribed by the Director, describing the manner in which the revised rating methodology and resultant rates differ from the existing rating methodology and existing ~~resultant~~ rates.

B) The issuer does not subsequently put into effect a change of rates or rating factors that would cause the percentage differential between the discontinued and subsequent rates as described in the acturial memorandum to change. The

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Director may approve a change to the differential which is in the public interest.

e) Except as provided herein, the experience of all policy forms or certificate forms of the same type in a standard Medicare supplement benefit plan shall be combined for purposes of the refund or credit calculation prescribed in Section 2008.80 of this Part. Forms assumed under an assumption reinsurance agreement shall not be combined with the experience of other forms for purposes of the refund or credit calculation.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.82 Permitted Compensation Arrangements**

a) An issuer or other entity may provide commission or other compensation to an insurance producer for the sale of a Medicare supplement policy or certificate only if the first year commission or other first year compensation is no more than 200 percent (200%) of the commission or other compensation paid for selling or servicing the policy or certificate in the second year or period.

b) The commission or other compensation provided in subsequent (renewal) years must be the same as that provided in the second year or period and must be provided for no fewer than five renewal years.

c) No issuer or other entity shall provide compensation to its insurance producers and no insurance producer shall receive compensation greater than the renewal compensation payable by the replacing issuer on renewal policies or certificates if an existing policy or certificate is replaced ~~unless benefits of the new policy or certificate are greater than the benefits under the replaced policy~~.

d) For purposes of this Section, "compensation" includes pecuniary or non-pecuniary remuneration of any kind relating to the sale or renewal of the policy or certificate including but not limited to bonuses, gifts, prizes, awards and finders fees.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.90 Required Disclosure Provisions**

a) General Rules

1) Medicare supplement policies and certificates shall include a renewal or continuation provision. The language or specifications of such provision must be consistent with the type of contract issued. Such provision shall be appropriately captioned and shall appear on the first page of the policy and shall include any reservation by the issuer of the right to change premiums and any automatic renewal premium increases based on the policyholder's age.

2) Except for riders or endorsements by which the issuer effectuates



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a request made in writing by the insured or exercises a specifically reserved right under a Medicare supplement policy, or is required to reduce or eliminate benefits to avoid duplication of Medicare benefits, all riders or endorsements added to a Medicare supplement policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the insured. After the date of policy or certificate issue, any rider or endorsement which increases benefits or coverage with an accompanying increase in premium during the policy term shall be agreed to in writing and signed by the insured, unless the benefits are required by the minimum standards for Medicare supplement policies, ~~be agreed to in writing signed by the insured,~~ except if the increased benefits or coverage is required by law. Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.

3) Medicare supplement policies or certificates shall not provide for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import.

4) If a Medicare supplement policy or certificate contains any limitations with respect to preexisting conditions, such limitations shall appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."

5) Medicare supplement policies and certificates shall have a notice prominently printed on the first page of the policy or certificate or attached thereto stating in substance that the policyholder or certificateholder shall have the right to return the policy or certificate within thirty (30) days of its delivery and to have the premium refunded directly to him or her in a timely manner if, after examination of the policy or certificate, the insured person is not satisfied for any reason.

6) Issuers of accident and sickness policies or certificates which provide hospital or medical expense coverage on an expense incurred or indemnity basis, ~~other than incidentally,~~ to a person(s) eligible for Medicare ~~by reason of age~~ shall provide to those ~~such~~ applicants a Guide to Health Insurance for People with Medicare ~~"buyer's guide"~~ approved by the Director of Insurance and in type size no smaller than 12 point type. Delivery of the Guide ~~"buyer's guide"~~ shall be made whether or not such policies or certificates are advertised, solicited or issued as Medicare supplement policies or certificates as defined in this Part. Except in the case of direct response issuers, delivery of the Guide ~~"buyer's guide"~~ shall be made to the applicant at the time of application and acknowledgement of receipt of the Guide ~~"buyer's guide"~~ shall be obtained by the issuer. Direct response issuers shall deliver the Guide ~~"buyer's guide"~~ to the applicant

upon request but not later than at the time the policy is delivered.

b) Policy Checklist

1) In order to determine what policy is appropriate and nonduplicative, a policy checklist must be completed in the presence of the applicant at the point of sale. Copies of the checklist, completed and duly signed are to be provided to the applicant and the issuer. This requirement does not apply to direct response solicitations.

2) The checklist required by subsection (b)(1) above shall provide substantially the form prescribed in Appendix A of this Part.

3) Issuers issuing Medicare supplement policies for delivery in this State shall not issue a Medicare supplement policy unless all information requested in the policy checklist is provided.

c) Notice Requirements

1) As soon as practicable, but no later than thirty (30) days prior to the annual effective date of Medicare benefit changes, an ~~every~~ insurer shall notify its policyholders and certificateholders of modifications it has made to Medicare supplement insurance policies or certificates in the format prescribed in Appendix O of this Part. Such notice shall:

A) Include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement policy or certificate, and

B) Inform each policyholder or certificateholder as to when any premium adjustment is to be made due to changes in Medicare.

2) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension. This notice shall be plainly printed in no smaller than twelve (12) point type.

3) Such notices shall not contain or be accompanied by any solicitation.

d) Outline of Coverage Requirements for Medicare Supplement Policies

1) Issuers shall provide an outline of coverage to all applicants at the time the application is presented to the prospective applicant, and except for direct response policies, shall obtain an acknowledgement of receipt of such outline from the applicant.

2) If an outline of coverage is provided at the time of application and the ~~a~~ Medicare supplement policy or certificate is issued on a basis which would require revision of the outline ~~of coverage delivered at the time of application~~, a substitute outline of coverage properly describing the policy or certificate ~~actually issued~~ shall accompany such policy or certificate when it is delivered and contain the following statement, in no less than twelve (12) point type, immediately above the company name:

NOTICE: Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon



application, and the coverage originally applied for has not been issued.

3) In addition to the statement required by subsection (d)(2) of this Section, each revised outline of coverage accompanying a policy or certificate issued on a basis other than that originally applied for, shall contain the following notice appearing in no less than twelve (12) point type:

WARNING: The (policy or certificate) you have received is not the same as the one for which you made application.

4) The outline of coverage provided to applicants pursuant to this subsection shall consist of four parts: a cover page, premium information, disclosure pages, and charts displaying the features of each benefit plan offered by the issuer. Please see Appendix B of this Part. The outline of coverage shall be in the language and format prescribed in Appendix B in no less than twelve (12) point type. All plans "A-J" shall be shown on the cover page, and the plan(s) that are offered by the issuer shall be prominently identified. Premium information for plans that are offered shall be shown on the cover page or immediately following the cover page and shall be prominently displayed. The premium and mode shall be stated for all plans that are offered to the prospective applicant. All possible premiums for the prospective applicant shall be illustrated.

5) The outline of coverage shall follow the format in Appendix B of this Part. The term "certificate" should be substituted for the word "policy" throughout the outline of coverage where appropriate.

e) Notice Regarding Policies or Certificates Which are Not Medicare Supplement Policies

1) Any accident and sickness insurance policy or certificate, other than a Medicare supplement policy, a policy issued pursuant to a contract under Section 1876 of the Federal Social Security Act (42 U.S.C., Section 1395 et seq.) disability income policy, or other policy identified in Section 2008.30(b)(3) of this Part issued for delivery in this State to persons eligible for Medicare, shall notify insureds under the policy that the policy is not a Medicare supplement policy or certificate. The ~~In the case wherein a policy, as defined in Section 355a(2)(a) of the Code, being sold to a person eligible for Medicare by reason of age provides one or more but not all of the minimum standards for Medicare supplements in Section 363 of the Code, such policy or certificate shall provide notice that such policy is not a Medicare supplement and does not meet the minimum benefits standards set for such policies in this State.~~ Such notice shall either be printed or attached to ~~appear on~~ the first page ~~of the policy or certificate on the first page~~ of the outline of coverage delivered to insureds under the policy, or if no outline of coverage is delivered, to the first page of the policy or

certificate delivered to insureds. The ~~Such~~ notice shall be in no less than twelve (12) point type and shall contain the following language:

THIS (POLICY OR CERTIFICATE) IS NOT A MEDICARE SUPPLEMENT (POLICY OR CERTIFICATE). IT DOES NOT FULLY SUPPLEMENT YOUR FEDERAL MEDICARE HEALTH INSURANCE. If you are eligible for Medicare, review the ~~Medicare--Supplement--Buyers~~ Guide to Health Insurance for People with Medicare available from the company.

2) Using the applicable statement found in Appendix Q of this Part, applications provided to persons eligible for Medicare for the health insurance policies or certificates described in subsection (e)(1) above shall disclose the extent to which the policy duplicates Medicare. The disclosure statement shall be provided as part of, or together with, the application or certificate.

~~f) Applications---Notice-regarding-policies-or-certificates-which-are-not Medicare-supplement-policies~~

~~In--the--case--wherein-an-application-is-used-to-apply-for-the-type-of policy-as-defined-in-subsection-(e)-of-this-Section,-such--application shall--provide--notice--that--the--policy--being--applied-for-is-not-a "Medicare-Supplement"-and-does-not-meet-the-minimum-benefits-standards set-forth-for-such-policies-in-this-State.--Such-notice-shall-be-in-no less-than-twelve-(12)-point--type--and--shall--contain--the--following language:~~

~~THIS--(POLICY,-CERTIFICATE-OR-SUBSCRIBER-CONTRACT)-WHICH-YOU HAVE-APPLIED-FOR-IS-NOT-A--MEDICARE--SUPPLEMENT--(POLICY--OR CERTIFICATE).---IT--DOES--NOT--FULLY-SUPPLEMENT-YOUR-FEDERAL MEDICARE--HEALTH--INSURANCE.---If--you--are---eligible---for Medicare,---review--the--Medicare--Supplement--Buyers--Guide available-from-the-company.~~

f)~~g~~) Filing Requirements for Advertising

~~i~~) An issuer of Medicare supplement insurance or benefits in this State shall provide a copy of any Medicare supplement advertisement intended for use in this State whether through written, radio or television medium to the Director of Insurance of this State for review by the Director to the extent it may be required under State law.

~~2) Notice--regarding-policies-or-certificates-which-are-not-Medicare supplement-policies.~~

~~In-the-case-wherein-any-advertising-as-defined-in--50--Ill.--Adm. Code--2002.40-(Advertising-of-Accident-and-Sickness-Insurance)-is used-to-solicit-the-type-of-policy-as-defined-in-subsection(e)-of this-Section,-such-advertising--shall--provide--notice--that--the policy-being-advertised-is-not-a-Medicare-supplement-and-does-not meet--the--minimum-benefits-standards-set-forth-for-such-policies in-this-State.--Such-notice-shall-be-prominently-disclosed-within the-text-of-the-advertisement.--Such-notice-shall-be-in--no--less than--twelve--(12)--point--type--and--shall-contain-the-following language:~~



~~THIS-(POLICY,-CERTIFICATE-OR-SUBSCRIBER-CONTRACT)-IS--NOT--A MEDICARE--SUPPLEMENT--(POLICY--OR-CERTIFICATE).---IT-DOES-NOT FULLY-SUPPLEMENT-YOUR-FEDERAL-MEDICARE-HEALTH-INSURANCE.---If you--are--eligible--for--Medicare,---review---the---Medicare Supplement-Buyers-Guide-available-from-the-company.~~

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.91 Instructions for Use of the Disclosure Statements for Health Insurance Policies Sold to Medicare Beneficiaries that Duplicate Medicare**

a) Federal law, P.L. 103-432, prohibits the sale of health insurance policies (the term policy or policies includes certificates) that duplicate Medicare benefits unless they will pay benefits without regard to other health coverage and they include the prescribed disclosure statement on or together with the application.

b) All types of health insurance policies that duplicate Medicare shall include one of the disclosure statements found in Appendix Q of this Part, according to the particular policy type involved, on the application or together with the application. The disclosure statement may not vary from those found in Appendix Q of this Part in terms of language or format (type size, type proportional spacing, bold character, line spacing, and usage of boxes around text).

c) State and Federal law prohibits insurers from selling a Medicare supplement policy to a person that already has a Medicare supplement policy except as a replacement.

d) Property/Casualty and Life insurance policies are not considered health insurance.

e) Disability income policies are not considered to provide benefits that duplicate Medicare.

f) The Federal law does not pre-empt Illinois law.

g) The Federal law does not pre-empt existing Illinois form filing requirements.

(Source: Added at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.100 Requirements for Application Forms and Replacement Coverage**

a) Application forms shall include the following questions designed to elicit information as to whether, as of the date of the application, the applicant has another Medicare supplement or other health insurance policy or certificate in force or whether a Medicare supplement policy or certificate is intended to replace any other accident and sickness policy or certificate presently in force. A supplementary application or other form to be signed by the applicant and insurance producer containing such questions and statements may be used.

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[STATEMENTS]:

1) You do not need more than one Medicare supplement policy.
2) If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
3) ~~2)~~ You ~~If you are 65 or older, you~~ may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
4) ~~3)~~ The benefits and premiums under your Medicare supplement policy can ~~will~~ be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your policy will be reinstituted if requested within 90 days of losing Medicaid eligibility.
5) ~~4)~~ Counseling services may be available in this State to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

[QUESTIONS]

To the best of your knowledge,

1) Do you have another Medicare supplement policy or certificate in force ~~(including health care service contract, health maintenance organization contract)~~?
   A) If so, with which company?
   B) If so, do you intend to replace your current Medicare supplement policy with this policy (certificate)?
2) Do you have any other health insurance coverage ~~policies~~ that provides ~~provide~~ benefits similar to ~~which~~ this Medicare supplement policy ~~would duplicate~~?
   A) If so, with which company?
   B) What kind of policy?
3) ~~If the answer to question 1 or 2 is yes, do you intend to replace these medical or health policies with this policy (certificate)~~?
4) ~~3)~~ Are you covered for medical assistance through the state ~~by~~ Medicaid program?
   A) As a Specified Low Income Medicare Beneficiary (SLMB)?
   B) As a Qualified Medicare Beneficiary (QMB)?
   C) For other Medicaid medical benefits?

b) Agents shall list any other health insurance policies they have sold to the applicant.
   1) List policies sold which are still in force.
   2) List policies sold in the past five (5) years which are no longer in force.



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c) In the case of a direct response issuer, a copy of the application or supplemental form, signed by the applicant and acknowledged by the insurer, shall be returned to the applicant by the insurer upon delivery of the policy.
d) Upon determining that a sale will involve replacement of Medicare supplement, an issuer, other than a direct response issuer, or its agent, shall furnish the applicant, prior to issuance or delivery of the Medicare supplement policy or certificate, a notice regarding replacement of accident and sickness coverage. One copy of such notice signed by the applicant and the insurance producer shall be provided to the applicant and an additional signed copy shall be retained by the issuer. A direct response issuer shall deliver to the applicant at the time of the issuance of the policy the notice regarding replacement of accident and sickness coverage in the form prescribed in Appendix M of this Part.
e) The notice required by subsection (d) above for an issuer, other than a direct response issuer, shall be provided in the form prescribed in Appendix M of this Part in no less than twelve (12) point type.
f) Subsections 1 and 2 of Appendix M (applicable to preexisting conditions) may be deleted by an issuer if the replacement does not involve application of a new preexisting condition limitation.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.101 Standards for Marketing**

a) An issuer, directly or through its producers, shall:
   1) Establish fair and accurate marketing procedures which comply with the standards set forth in Section ~~Sections~~ 363a(5) and (6) of the Code.
   2) Establish marketing procedures to assure duplicative insurance benefits are not sold or issued.
   3) Display prominently by type, stamp or other appropriate means, on the first page of the policy, the following:
      "Notice to buyer: This policy may not cover all of your medical expenses."
   4) Inquire and otherwise make every reasonable effort to identify whether ~~of~~ a prospective applicant or enrollee for Medicare supplement insurance already has ~~whether they are currently covered by~~ accident and sickness insurance and the types and amounts of such insurance.
   5) Establish auditable procedures for verifying compliance with this subsection (a).
b) The following acts and practices are prohibited:
   1) Twisting. Knowingly making any misleading representation or incomplete or fraudulent comparison of any insurance policies or insurers for the purpose of inducing or tending to induce any person to lapse, forfeit, surrender, terminate, retain, pledge,

assign, borrow on, or convert any insurance policy or to take out a policy of insurance with another insurer.

2) High pressure tactics. Employing any method of marketing having the effect of inducing or tending to induce the purchase of insurance through force, fright, threat, whether explicit or implied, or undue pressure to purchase or recommend the purchase of insurance.

3) Cold lead advertising. Making use directly or indirectly of any method of marketing which fails to disclose in a conspicuous manner that a purpose of the method of marketing is solicitation of insurance and that contact will be made by an insurance agent or insurance company.

c) The terms "Medicare Supplement," "Medigap," "Medicare Wrap-Around" and words of similar import shall not be used unless the policy is issued in compliance with this Part.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

**Section 2008.104 Prohibition Against Preexisting Conditions, Waiting Periods, Elimination Periods and Probationary Periods in Replacement Policies or Certificates**

a) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate, the replacing issuer shall waive any time periods applicable to preexisting conditions, waiting periods, elimination periods and probationary periods in the new Medicare supplement policy or certificate for similar benefits to the extent such time was spent under the original policy.

b) If a Medicare supplement policy or certificate replaces another Medicare supplement policy or certificate which has been in effect for at least six months, the replacing policy shall not provide any time period applicable to preexisting conditions, waiting periods, elimination periods and probationary periods for benefits similar to those contained in the original policy or certificate.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)



**Section 2008.APPENDIX M Notice to Applicant Regarding Replacement of Accident and Sickness Insurance**

Insurance company's name and address

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE

According to (your application) (information you have furnished) you intend to terminate existing accident and sickness insurance and replace it with a policy to be issued by (Company Name) Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If ~~Terminate your present policy only if,~~ after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision you should terminate your present Medicare supplement coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY INSURANCE PRODUCER:

I have reviewed your current medical or health insurance coverage. To ~~The replacement of insurance involved in this transaction does not duplicate coverage, to~~ the best of my knowledge this Medicare supplement policy will not duplicate your existing Medicare supplement coverage because you intend to terminate your existing Medicare supplement coverage. The replacement policy is being purchased for the following reason(s) (Check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ Other. (please specify) _____

_____

_____

1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) ~~State law~~ †Section 363(7)(b) of the Illinois Insurance Code [215 ILCS 5/363(7)(b)] ~~, Ill. Rev. Stat. 1991, ch. 73, par. 975~~) provides that your replacement policy or certificate may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

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3) If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded. [If the policy or certificate is guaranteed issue, this paragraph need not appear.]

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
(Signature of Insurance Producer or Other Representative)

Typed Name and Address of Issuer or Insurance Producer

_____
(Applicant's Signature)

_____
Date

* Signature not required for direct response sales.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)



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**SECTION 2008. APPENDIX N Medicare Supplement Refund Calculation Format**

**For Calendar Year _____**

**Type (1)** _____ **SMSBP (w2)** _____

**For the State of** _____

**Company Name** _____

**NAIC Group Code** _____ **NAIC Company Code** _____

**Address** _____

**Person Completing this Form** _____

**Title** _____ **Telephone Number** _____

| Line | | (a) Earned Premium (x3) | (b) Incurred Claims (y4) |
|---|---|---|---|
| 1. | Current Year's Experience | | |
| | a. Total (all policy years) | | |
| | b. Current year's issues (z) | | |
| | c. Net (for reporting purposes = 1a – 1b) | | |
| 2. | Past Year's Experience (all policy years) | | |
| 3. | Total Experience (net current year + past year's experience) | | |

4. Refunds last year (excluding interest) _____

5 Previous since Inception (excluding interest) _____

6. Refunds since Inception (excluding interest) _____

7 Benchmark Ratio since Inception _____
**(see worksheet for Ratio 1)**

8 Experienced Ratio since Inception

Total Actual Incurred Claims (line 3, col. b) / Total Premium After Refunds = Ratio 2

Where Total Earned Premium after Refunds = Total Earned Premiums (line 3, col. a) – Refunds since Inception (line 6)

9. Life Years Exposed Since Inception
***If the Experienced Ratio is less than the Benchmark Ratio, and there are more than 500 life years exposure, then proceed to calculation of refund.***

10. Tolerance Permitted _____
(obtained from credibility table)

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11. Adjustment to Incurred Claims for Credibility

    Ratio 3 = Ratio 2 + Tolerance _____

    ***If ratio 3 is more than benchmark ratio (ratio 1), a refund or credit to premium is not required.***

    ***If ratio 3 is less than the benchmark ratio, then proceed.***

12. Adjusted Incurred Claims = Total Earned Premiums (line 3, col. a) – Refunds since Inception (line 6) x Ratio 3 (line 11). _____

13. Refund = Total Earned Premium after Refunds – [Adjusted Incurred Claims (line 12) / Benchmark Ratio (Ratio 1)]_____

    Where Total Earned Premium after Refunds = Total Earned Premiums (line 3, col. a) – Refunds since Inception (line 6)

    ***If the amount on line 13 is less than .005 times the annualized premium in force as of December 31 of the reporting year, then no refund is made. Otherwise, the amount on line 13 is to be refunded or credited, and a description of the refund and/or credit against premiums to be used must be attached to this form.***

**Medicare Supplement Credibility Table**

| Life Years Exposed Since Inception | Tolerance |
|---|---|
| 10,000 + | 0.0% |
| 5,000 – 9,999 | 5.0% |
| 2,500 – 4,999 | 7.5% |
| 1,000 – 2,499 | 10.0% |
| 500 – 999 | 15.0% |

If less than 500, no credibility

(1) Individual, Group, Individual Medicare Select, or Group Medicare Only.
(~~w~~2) "SMSBP" = Standard Medicare Supplement Benefit Plan–Use "P" for pre-standardized plans.
(~~x~~3) Includes modeal loadings and fees charged
(~~y~~4) Excludes Active Life Reserves
(~~z~~5) This is to be used as "Issue Year Earned Premium" for 1 of next year's "Worksheet for Calculation of Benchmark Ratios"

I certify that the above information and calculations are true and accurate to the best of my knowledge and belief

**Signature** **Title–please type**

**Name–please type** **Date**



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**~~WORKSHEET~~REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR GROUP POLICIES**
**For Calendar Year _____**

**Type (1):** _____ **SMSBP (2):** _____

**For the State of:** _____

**Company Name:** _____

**NAIC Group Code:** _____ **NAIC Company Code:** _____

**Address:** _____

**Person Completing Form:** _____

**Title:** _____ **Telephone Number:** _____

| (a3) Year | (b4) Earned Premium | (c) Factor | (d) (b4) x (c) | (e) Cumulative Loss Ratio | (f) (d) x (e) | (g) Factor | (h) (b4) x (g) | (i) Cumulative Loss Ratio | (j) (h) x (i) | (o5) Policy Year Loss Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | 2.770 | | 0.507 | | 0.000 | | 0.000 | | 0.46 |
| 2 | | 4.175 | | 0.567 | | 0.000 | | 0.000 | | 0.63 |
| 3 | | 4.175 | | 0.567 | | 1.194 | | 0.759 | | 0.75 |
| 4 | | 4.175 | | 0.567 | | 2.245 | | 0.771 | | 0.77 |
| 5 | | 4.175 | | 0.567 | | 3.170 | | 0.782 | | 0.80 |
| 6 | | 4.175 | | 0.567 | | 3.998 | | 0.792 | | 0.82 |
| 7 | | 4.175 | | 0.567 | | 4.754 | | 0.802 | | 0.84 |
| 8 | | 4.175 | | 0.567 | | 5.445 | | 0.811 | | 0.87 |
| 9 | | 4.175 | | 0.567 | | 6.075 | | 0.818 | | 0.88 |
| 10 | | 4.175 | | 0.567 | | 6.650 | | 0.824 | | 0.88 |
| 11 | | 4.175 | | 0.567 | | 7.176 | | 0.828 | | 0.88 |
| 12 | | 4.175 | | 0.567 | | 7.655 | | 0.831 | | 0.88 |
| 13 | | 4.175 | | 0.567 | | 8.093 | | 0.834 | | 0.89 |
| 14 | | 4.175 | | 0.567 | | 8.493 | | 0.837 | | 0.89 |
| 15 | | 4.175 | | 0.567 | | 8.684 | | 0.838 | | 0.89 |
| Total: | | | (k): | | (l): | | (m): | | (n): | |

Benchmark Ratio Since Inception: Ratio 1 = (l + n) / (k + m) _____

(1): Individual, Group, Individual Medicare Select, or Group Medicare Select Only.

(~~p~~2): "SMSBP" = Standardized Medicare Supplement Benefit Plan–Use "P" for pre-standardized plans.

(~~a~~3): Year 1 is the current calendar year–1
Year 2 is the current calendar year–2 (etc.)
(Example: If the current year is 1991, then Year 1 is 1990; Year 2 is 1989, etc.)

(~~b~~4): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(~~o~~5): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

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**~~WORKSHEET~~REPORTING FORM FOR THE CALCULATION OF BENCHMARK RATIO SINCE INCEPTION FOR INDIVIDUAL POLICIES**
**For Calendar Year _____**

**Type (1):** _____ **SMSBP (2):** _____

**For the State of:** _____

**Company Name:** _____

**NAIC Group Code:** _____ **NAIC Company Code:** _____

**Address:** _____

**Person Completing Form:** _____

**Title:** _____ **Telephone Number:** _____

| (a3) Year | (b4) Earned Premium | (c) Factor | (d) (b4) x (c) | (e) Cumulative Loss Ratio | (f) (d) x (e) | (g) Factor | (h) (b4) x (g) | (i) Cumulative Loss Ratio | (j) (h) x (i) | (o5) Policy Year Loss Ratio |
|---|---|---|---|---|---|---|---|---|---|---|
| 1 | | 2.770 | | 0.442 | | 0.000 | | 0.000 | | 0.4 |
| 2 | | 4.175 | | 0.493 | | 0.000 | | 0.000 | | 0.55 |
| 3 | | 4.175 | | 0.493 | | 1.194 | | 0.659 | | 0.65 |
| 4 | | 4.175 | | 0.493 | | 2.245 | | 0.669 | | 0.67 |
| 5 | | 4.175 | | 0.493 | | 3.170 | | 0.678 | | 0.69 |
| 6 | | 4.175 | | 0.493 | | 3.998 | | 0.686 | | 0.71 |
| 7 | | 4.175 | | 0.493 | | 4.754 | | 0.695 | | 0.73 |
| 8 | | 4.175 | | 0.493 | | 5.445 | | 0.702 | | 0.75 |
| 9 | | 4.175 | | 0.493 | | 6.075 | | 0.708 | | 0.76 |
| 10 | | 4.175 | | 0.493 | | 6.650 | | 0.713 | | 0.76 |
| 11 | | 4.175 | | 0.493 | | 7.176 | | 0.717 | | 0.76 |
| 12 | | 4.175 | | 0.493 | | 7.655 | | 0.720 | | 0.77 |
| 13 | | 4.175 | | 0.493 | | 8.093 | | 0.723 | | 0.77 |
| 14 | | 4.175 | | 0.493 | | 8.493 | | 0.725 | | 0.77 |
| 15 | | 4.175 | | 0.493 | | 8.684 | | 0.725 | | 0.77 |
| Total: | | | (k): _____ | | (l): _____ | | (m): _____ | | (n): _____ | |

Benchmark Ratio Since Inception: Ratio 1 = (l + n) / (k + m): _____

(1): Individual, Group, Individual Medicare Select, or Group Medicare only.

(p2): "SMSBP" = Standardized Medicare Supplement Benefit Plan—Use "P" for pre-standardized plans.

(a3): Year 1 is the current calendar year–1
Year 2 is the current calendar year–2 (etc.)
(Example: If the current year is 1991, then Year 1 is 1990; Year 2 is 1989, etc.)

(b4): For the calendar year on the appropriate line in column (a), the premium earned during that year for policies issued in that year.

(o5): These loss ratios are not explicitly used in computing the benchmark loss ratios. They are the loss ratios, on a policy year basis, which result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1996.)

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result in the cumulative loss ratios displayed on this worksheet. They are shown here for informational purposes only.

~~(p)~~: ~~"SMSBP"--Standardized Medicare Supplement Benefit Plan~~

(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)

2008.APPENDIX Q Disclosure Statements

All types of health insurance policies that duplicate Medicare shall include one of the following disclosure statements according to the particular policy type involved, on the application or together with the application. The disclosure statement language and format may not vary in type size, type proportional spacing, bold character, line spacing or usage of boxes around text from those presented below.

a) For policies that provide benefits for expenses incurred for an accidental injury only:

[ IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS ]

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses that result from accidental injury. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when it pays hospital medical expenses up to the maximum stated in the policy.**

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- other approved items and services.

[ Before You Buy This Insurance ]

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.



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b) For policies that provide benefits for specified limited services:

[ IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS ]

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when any of the services covered by the policy are also covered by Medicare.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- other approved items and services.

[ Before You Buy This Insurance ]

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

c) For policies that reimburse expenses for specified disease or other specified impairments. This includes expense incurred cancer, specified disease and other types of health insurance policies that limit reimbursement to named medical conditions:

[ IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS ]

**This is not Medicare Supplement Insurance**

This insurance provides limited benefits, if you meet the policy conditions, for hospital or medical expenses only when you are treated

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for one of the specific diseases or health conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays hospital or medical expenses up to the maximum stated in the policy.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization,
- physician services,
- hospice,
- other approved items and services.

Before You Buy This Insurance

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

d) For policies that pay fixed dollar amounts for specified diseases or other specified impairments. This includes cancer, specified disease, and other health insurance policies that pay a scheduled benefit or specific payment based on diagnosis of the conditions named in the policy:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance pays a fixed amount, regardless of your expenses, if you meet the policy conditions, for one of the specific diseases or health conditions named in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits because Medicare generally pays for most of the expenses for the diagnosis and treatment of the specific conditions or diagnoses named in the policy.



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Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization,
- physician services,
- hospice,
- other approved items and services.

Before You Buy This Insurance

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

e) For indemnity policies and other policies that pay a fixed dollar amount per day, excluding long-term care policies:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when any expenses or services covered by the policy are also covered by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization,
- physician services,
- hospice,
- other approved items and services.

Before You Buy This Insurance

- Check the coverage in all health insurance policies you already

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have.
For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

f) For policies that provide benefits for both expenses incurred and fixed indemnity basis:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

**This is not Medicare Supplement Insurance**

This insurance pays limited reimbursement for expenses if you meet the conditions listed in the policy. It also pays a fixed amount, regardless of your expenses, if you meet other policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**This insurance duplicates Medicare benefits when:**

- any expenses or services covered by the policy are also covered by Medicare; or
- it pays the fixed dollar amount stated in the policy and Medicare covers the same event.

**Medicare generally pays for most or all of these expenses.**

**Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:**

- hospitalization,
- physician services,
- hospice care,
- other approved items and services.

**Before You Buy This Insurance**

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling



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program.

g) For long-term care policies providing both nursing home and non-institutional coverage:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

**This is not Medicare Supplement Insurance**

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This is long-term care insurance that provides benefits for covered nursing home and home care services.
- In some situations Medicare pays for short periods of skilled nursing home care, limited home health services and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

**Neither Medicare nor Medicare Supplement insurance provides benefits for most long-term care expenses.**

**Before You Buy This Insurance**

- Check the coverage in all health insurance policies you already have.
- For more information about long-term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

h) For policies providing nursing home benefits only:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

**This is not Medicare Supplement Insurance**

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

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- This insurance provides benefits primarily for covered nursing home services.
- In some situations Medicare pays for short periods of skilled nursing home care and hospice care.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most nursing home expenses.

Before You Buy This Insurance

- Check the coverage in all health insurance policies you already have.
- For more information about long-term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

i) For policies providing home care benefits only:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

Federal law requires us to inform you that this insurance duplicates Medicare benefits in some situations.

- This insurance provides benefits primarily for covered home care services.
- In some situations, Medicare will cover some health related services in your home and hospice care which may also be covered by this insurance.
- This insurance does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Neither Medicare nor Medicare Supplement insurance provides benefits for most services in your home.

Before You Buy This Insurance



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- Check the coverage in all health insurance policies you already have.
- For more information about long-term care insurance, review the Shopper's Guide to Long Term Care Insurance, available from the insurance company.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

j) For other health insurance policies not specifically identified in the previous statements:

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits if you meet the conditions listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when it pays the benefits stated in the policy and coverage for the same event is provided by Medicare.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization,
- physician services,
- hospice,
- other approved items and services.

Before You Buy This Insurance

- Check the coverage in all health insurance policies you already have.
- For more information about Medicare and Medicare Supplement insurance, review the Guide to Health Insurance for People with Medicare, available from the insurance company.
- For help in understanding your health insurance, contact your state insurance department or state senior insurance counseling program.

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(Source: Amended at 20 Ill. Reg. _____, effective April 28, 1995)



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1) Heading of the Part: Retailers' Occupation Tax

2) Code Citation: 86 Ill. Adm. Code 130

3)

| Section Numbers: | Proposed Action: |
|---|---|
| 130.501 | Amendment |
| 130.502 | Amendment |
| 130.510 | Amendment |
| 130.535 | Amendment |
| 130.540 | Amendment |

4) Statutory Authority: 35 ILCS 120

5) A Complete Description of the Subjects and Issues Involved: Between the time this Part was originally drafted and the time this Part was proposed, P.A. 87-14 amended the Retailers' Occupation Tax Act in a number of respects. This rulemaking amends Sections 130.501(a), 130.502(a), 130.510(a) and 130.540(c) to conform the quote of statutory language to the exact language of the Retailers' Occupation Tax Act.

Also, this rulemaking implements various provisions of Public Act 89-379. Specifically, it amends Section 130.501 of the Department's regulations governing monthly tax returns by stating that returns must be signed, and that if a taxpayer fails to sign a return within 30 days after notice and demand for signature by the Department, the return shall be considered valid and any amount shown to be due on the return shall be deemed assessed. It also amends Section 130.535 to state that beginning January 1, 1996, quarter-monthly filers must pay an amount equal to either 22.5% of the taxpayer's actual liability for the month or 25% of the taxpayer's liability for the same calendar month of the preceding year. Between January 1, 1989 and January 1, 1996, such taxpayer also has the option (in addition to the payments described above) to pay an amount equal to 100% of the taxpayer's actual liability for the quarter-monthly reporting period. The rulemaking also makes other technical requirements governing credits available to quarter-monthly filers.

6) Will this proposed rule replace an emergency rule currently in effect: No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part: Yes

| Section Numbers | Proposed Action | Illinois Register Citation |
|---|---|---|
| 130.331 | Amendment | 19 Ill. Reg. 571 |

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| | | |
|---|---|---|
| 130.305 | Amendment | 19 Ill. Reg. 14336 |
| 130.120 | Amendment | 19 Ill. Reg. 14752 |

10) Statement of Statewide Policy Objectives: This rulemaking does not create a State Mandate, nor does it modify any existing State Mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Phillip McCollum
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, IL 62794
(217) 782-6996

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses affected: No new procedures are required that would impact small businesses.

B) Reporting, bookkeeping or other procedures required for compliance: None.

C) Types of professional skills necessary for compliance: None.

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Amendment(s) begins on the next page:



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TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 130
RETAILERS' OCCUPATION TAX

SUBPART A: NATURE OF TAX



SUBPART B: SALE AT RETAIL



SUBPART C: CERTAIN STATUTORY EXEMPTIONS



SUBPART D: GROSS RECEIPTS

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SUBPART E: RETURNS



SUBPART F: INTERSTATE COMMERCE



SUBPART G: CERTIFICATE OF REGISTRATION





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SUBPART H: BOOKS AND RECORDS



SUBPART I: PENALTIES AND INTEREST



SUBPART J: BINDING OPINIONS



SUBPART K: SELLERS LOCATED ON, OR SHIPPING TO, FEDERAL AREAS



SUBPART L: TIMELY MAILING TREATED AS TIMELY FILING AND PAYING



SUBPART M: LEASED PORTIONS OF LESSOR'S BUSINESS SPACE

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AUTHORITY: Implementing the Illinois Retailers' Occupation Tax Act [35 ILCS 120] and authorized by Section 39b3 of the Civil Administrative Code of Illinois [20 ILCS 2505/39b3].

SOURCE: Adopted July 1, 1933; amended at 2 Ill. Reg. 50, p. 71, effective December 10, 1978; amended at 3 Ill. Reg. 12, p. 4, effective March 19, 1979; amended at 3 Ill. Reg. 13, pp. 93 and 95, effective March 25, 1979; amended at 3 Ill. Reg. 23, p. 164, effective June 3, 1979; amended at 3 Ill. Reg. 25, p. 229, effective June 17, 1979; amended at 3 Ill. Reg. 44, p. 193, effective October 19, 1979; amended at 3 Ill. Reg. 46, p. 52, effective November 2, 1979; amended at 4 Ill. Reg. 24, pp. 520, 539, 564 and 571, effective June 1, 1980; amended at 5 Ill. Reg. 818, effective January 2, 1981; amended at 5 Ill. Reg. 3014, effective March 11, 1981; amended at 5 Ill. Reg. 12782, effective November 2, 1981; amended at 6 Ill. Reg. 2860, effective March 3, 1982; amended at 6 Ill. Reg. 6780, effective May 24, 1982; codified at 6 Ill. Reg. 8229; recodified at 6 Ill. Reg. 8999; amended at 6 Ill. Reg. 15225, effective December 3, 1982; amended at 7 Ill. Reg. 7990, effective June 15, 1983; amended at 8 Ill. Reg. 5319, effective April 11, 1984; amended at 8 Ill. Reg. 19062, effective September 26, 1984; amended at 10 Ill. Reg. 1937, effective January 10, 1986; amended at 10 Ill. Reg. 12067, effective July 1, 1986; amended at 10 Ill. Reg. 19538, effective November 5, 1986; amended at 10 Ill. Reg. 19772, effective November 5, 1986; amended at 11 Ill. Reg. 4325, effective March 2, 1987; amended at 11 Ill. Reg. 6252, effective March 20, 1987; amended at 11 Ill. Reg. 18284, effective October 27, 1987; amended at 11 Ill. Reg. 18767,



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effective October 28, 1987; amended at 11 Ill. Reg. 19138, effective October 29, 1987; amended at 11 Ill. Reg. 19696, effective November 23, 1987; amended at 12 Ill. Reg. 5652, effective March 15, 1988; emergency amendment at 12 Ill. Reg. 14401, effective September 1, 1988, for a maximum of 150 days, modified in response to an objection of the Joint Committee on Administrative Rules at 12 Ill. Reg. 19531, effective November 4, 1988, not to exceed the 150 day time limit of the original rulemaking; emergency expired January 29, 1989; amended at 13 Ill. Reg. 11824, effective June 29, 1989; amended at 14 Ill. Reg. 241, effective December 21, 1989; amended at 14 Ill. Reg. 872, effective January 1, 1990; amended at 14 Ill. Reg. 15463, effective September 10, 1990; amended at 14 Ill. Reg. 16028, effective September 18, 1990; amended at 15 Ill. Reg. 6621, effective April 17, 1991; amended at 15 Ill. Reg. 13542, effective August 30, 1991; amended at 15 Ill. Reg. 15757, effective October 15, 1991; amended at 16 Ill. Reg. 1642, effective January 13, 1992; amended at 17 Ill. Reg. 860, effective January 11, 1993; amended at 17 Ill. Reg. 18142, effective October 4, 1993; amended at 17 Ill. Reg. 19651, effective November 2, 1993; amended at 18 Ill. Reg. 1537, effective January 13, 1994; amended at 18 Ill. Reg. 16866, effective November 7, 1994; amended at 19 Ill. Reg. 13446, effective September 12, 1995; amended at 19 Ill. Reg. 13568, effective September 11, 1995; amended at 19 Ill. Reg. 13968, effective September 18, 1995; amended at 20 Ill. Reg. _____, effective _____.

SUBPART E: RETURNS

**Section 130.501 Monthly Tax Returns -- When Due -- Contents**

a) Except as provided in Section 130.502, 130.510 and 130.2045, on or before the twentieth ~~last~~ day of each calendar month, every person engaged in the business of selling tangible personal property at retail in this State during the preceding calendar month shall file a return with the Department for such preceding month, stating the name of the seller; his residence address and the address of his principal place of business, and the address of the principal place of business (if that is a different address) from which he engaged in the business of selling tangible personal property at retail in this State.

b) In addition, the return shall disclose the following:

1) Total Receipts for the Month from Sales of Tangible Personal Property and Services. Real estate builders and construction contractors, who are also retailers, and who assume the responsibility for accounting for the tax on building materials which they purchase, must include, in total receipts, not only their receipts from "over-the-counter" resales of such materials, but also their cost prices of such materials which they convert into real estate (see ~~See~~ Section 130.2075 of this Part). This may be accomplished in the case of a construction contractor by including his receipts from construction contracts in total receipts and by deducting such receipts from total receipts only to the extent to which such receipts exceed the cost price to

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the contractor of the tangible personal property which he incorporates into real estate as a construction contractor.

2) Deductions Allowed by Law
The taxpayer should include in his total receipts, but should deduct before computing the amount of the tax:
A) taxes collected from sales of the following:
i) general merchandise retail sales,
ii) general merchandise service sales,
iii) food, drugs and medical appliances retail sales,
iv) food, drugs and medical appliances service sales;~~,~~
B) receipts from sales of tangible personal property for purposes of resale in any form as tangible personal property (see Subparts B and N of this Part);
C) receipts from sales which are within the protection of the Commerce Clause of the Constitution of the United States (see Subpart F of this Part);
D) cash refunds for returned merchandise (see Section 130.401 of this Part);
E) receipts from the sales of newspapers and magazines (see Section 130.2105 of this Part);
F) State motor fuel taxes collected;
G) the exempt percentage of the receipts from sales of gasohol (see Section 130.320 of this Part);
H) receipts from sales of any kind to any corporation, society, association, foundation or institution organized and operated exclusively for charitable, religious or educational purposes or any not-for-profit corporation, society, association, foundation, institution or organization which has no compensated officers or employees and which is organized and operated primarily for the recreation of persons 55 years of age and older (see Section 130.2005 of this Part);
I) receipts from sales of any kind to a governmental body (see Section 130.2080 of this Part);
J) receipts from nontaxable sales of service;
K) any other deduction allowed by law, such as receipts from isolated or occasional sales (see Subpart A of this Part); Federal taxes that are imposed at the level of the retail sale, but not Federal excise taxes on manufacturers, etc. (see Section 130.445 of this Part), etc.;
L) total of all deductions allowed by law.

3) Total Receipts which are obtained by subtracting deductions from total receipts.

4) The Amount of Tax Due
A) An allowance to reimburse the taxpayer for the expenses incurred in keeping records, preparing and filing returns, remitting the tax and supplying data to the Department on request. The minimum discount, over the entire period of



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any given calendar year, for any single taxpayer (if the taxpayer incurs that much tax liability) shall be $5.00 for such calendar year. This allowance is available when the tax is remitted with a return that is filed when due under the Act, but is not available in any case in which the tax is paid late (with or without a return, and whether formally assessed by the Department or not); in the case of retailers who report and pay the tax on a transaction by transaction basis, such discount shall be taken with each such tax remittance instead of when such retailer files his periodic return;

B) Balance of Tax Due.
i) The return should also show the amount of penalty (if any) that is due, the total of the tax and penalty due, and such other reasonable information as the Department may require.
ii) *If a total amount of less than $1 is payable, refundable or creditable, such amount shall be disregarded if it is less than 50 cents and shall be increased to $1 if it is 50 cents or more. Any amount which is required to be shown or reported on any return or other document under this Act shall, if such amount is not a whole-dollar amount, be increased to the nearest whole-dollar amount in any case where the fractional part of a dollar is 50 cents or more, and decreased to the nearest whole-dollar amount where the fractional part of a dollar is less than 50 cents* (Section 3 of the Act).
iii) The Department may require returns to be filed on a quarterly basis. If so required, a return for each calendar quarter shall be filed on or before the last day of the calendar month following the end of such calendar quarter. The taxpayer shall also file a return with the Department for each of the first two months of each calendar quarter, on or before the last day of the following calendar month, stating:
*The name of the seller;*
*The address of the principal place of business from which he engages in the business of selling tangible personal property at retail in this state;*
*The total amount of taxable receipts received by him during the preceding calendar month from sales of tangible personal property by him during such preceding calendar month, including receipts from charge and the sales, but less all deductions allowed by law;*
*The amount of credit provided in Section 2d of this Act;*

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*The amount of tax due;*
*The amount of penalty due, if any; and*
Such other reasonable information as the Department may require. (See Section 3 of the Act)

c) Returns must be signed by the taxpayer. If a taxpayer fails to sign a return within 30 days after proper notice and demand for signature by the Department, the return shall be considered valid and any amount shown to be due on the return shall be deemed assessed.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 130.502 Quarterly Tax Returns**

a) If the retailer is otherwise required to file a monthly return and if the retailer's average monthly tax liability to the Department does not exceed $200.00, the Department may authorize his returns to be filed on a quarter-annual basis, with the return for January, February and March of a given year being due by April 20 ~~30~~ of such year; with the return for April, May and June of a given year being due by July 20 ~~31~~ of such year; with the return for July, August and September of a given year being due by October 20 ~~31~~ of such year, and with the return for October, November and December of a given year being due by January 20 ~~31~~ of the following year.
b) The decision to permit quarterly filing will be based on the taxpayer's average monthly liability during the first year of registration. All taxpayers are required to file monthly returns unless authorized or required to file on a quarterly or annual basis.
c) Such quarterly returns, as to form and substance, shall be subject to the same requirements as monthly returns.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 130.510 Annual Tax Returns**

a) If the retailer's average monthly tax liability to the Department does not exceed $50.00, the Department may authorize his returns to be filed on an annual basis, with the return for a given year being due by January 20 ~~31~~ of the following year. The decision to permit annual filing will be based upon the taxpayer's average monthly liability during the first year of registration, or the first quarter of registration if the average monthly liability is less than $12.00. All taxpayers are required to file monthly returns unless authorized or required to file on a quarterly or an annual basis.
b) Such annual returns, as to form and substance, shall be subject to the same requirements as monthly returns.



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(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 130.535 Payment of the Tax, Including Quarter Monthly Payments in Certain Instances**

a) Except as noted hereinafter, at the same time that a tax return required by the provisions of the Act is filed with the Department, the taxpayer shall pay the tax that is due with such return to the Department.
b) If the taxpayer's average monthly tax liability to the Department under the Retailers' Occupation Tax Act, the Use Tax Act, the Service Occupation Tax Act, the Service Use Tax Act, excluding any liability for prepaid sales tax to be remitted in accordance with Section 2d of the Act, was $10,000 or more during the preceding 4 complete calendar quarters, he shall file a return with the Department each month by the 20th day of the month next following the month during which such tax liability is incurred and shall make payments to the Department on or before the 7th, 15th, 22nd and last day of the month during which such liability is incurred. If the month during which such tax liability is incurred begins on or after January 1, 1988, and prior to January 1, 1989, or begins on or after January 1, 1996, each ~~Each~~ payment shall be in an amount equal to 22.5% of the taxpayer's actual liability for the month or 25% of the taxpayer's liability for the same calendar month of the preceding year. If the month during which such tax liability is incurred begins on or after January 1, 1989, and prior to January 1, 1996, each payment shall be in an amount equal to 22.5% of the taxpayer's actual liability for the month or 25% of the taxpayer's liability for the same calendar month of the preceding year or 100% of the taxpayer's actual liability for the quarter monthly reporting period. The amount of such payments shall be credited against the final tax liability of the taxpayer's return for that month. If any such payment is not paid at the time required herein, then the taxpayer's 2%, 2.1% or 1.75% vendors' discount shall be reduced by 2%, 2.1% or 1.75% of the difference between the minimum amount due as a payment and the amount of such quarterly monthly payment actually and timely paid, and the taxpayer shall be liable for penalties and interest on such difference except insofar as the taxpayer has previously made payments for that month to the Department in excess fo the minimum payments previously due as provided in this Section.
c) *Without regard to whether a taxpayer is required to make quarter monthly payments as specified above, any taxpayer who is required by Section 2d of this Act to collect and remit prepaid taxes and has collected prepaid taxes which average in excess of $25,000 per month during the preceding 2 complete calendar quarters, shall file a return with the Department as required by Section 2f and shall make payments to the Department on or before the 7th, 15th, 22nd and last day of the*

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*month during which such liability is incurred. If the month during which such tax liability is incurred begins on or after January 1, 1987, each payment shall be in an amount equal to 22.5% of the taxpayer's actual liability for the month or 26.25% of the taxpayer's liability for the same calendar month of the preceding year. The amount of such quarter monthly payments shall be credited against the final tax liability of the taxpayer's return for that month filed under this Section or Section 2f, as the case may be. Once applicable, the requirement of the making of quarter monthly payments to the Department pursuant to this paragraph shall continue until such taxpayer's average monthly prepaid tax collections during the preceding 2 complete calendar quarters is $25,000 or less. If any such quarter monthly payment is not paid at the time or in the amount required, the taxpayer shall be liable for penalties and interest on such difference, except insofar as the taxpayer has previously made payments for that month in excess of the minimum payments previously due.* (Section 3 of the Act)

d) If any such payment or deposit provided for herein exceeds the taxpayer's present and probable future liabilities under the Retailers' Occupation Tax Act, the Use Tax Act, the Service Occupation Tax Act and the Service Use Tax Act, the Department shall, if requested by the taxpayer, issue to the taxpayer a credit memorandum, which may be submitted by the taxpayer to the Department in payment of tax liability subsequently to be remitted by the taxpayer to the Department or be assigned by the taxpayer to a similar taxpayer under the Retailers' Occupation Tax Act, the Use Tax Act, the Service Occupation Tax Act or the Service Use Tax Act. If no such request is made, the taxpayer may credit such excess payment against tax liability subsequently to be remitted to the Department under the Act, the Use Tax Act, the Service Occupation Tax Act or the Service Use Tax Act. If the Department subsequently determines that all or any part of the credit taken was not actually due to the taxpayer, the taxpayer's 2.1% and 1.75% vendor's discount shall be reduced by 2.1% or 1.75% of the difference between the credit taken and that actually due, and that taxpayer shall be liable for penalties and interest on such difference.

e) Any deposit previously made by a taxpayer who is required to make quarter monthly payments shall be applied against the taxpayer's liability to the Department under the Retailers' Occupation Tax Act, the Use Tax Act, the Service Occupation Tax Act or the Service Use Tax Act for the month preceding the first month in which the taxpayer is required to make such quarter monthly payments. If the deposit exceeds that liability, the Department shall issue the taxpayer a credit memorandum for the excess.

f) For the purposes of this Section, the phrase "preceding 4 complete calendar quarters" means the preceding 4 complete calendar quarters for which returns would have been filed or should have been filed for the last month of the 4 quarter period since, until then, the making



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of the required computations for the 4 quarter period would be impossible. For example, the preceding 4 complete calendar quarters with reference to a November 1, 1976, date would actually have ended June 30, 1976, since most returns for the last month of that 4 quarter period would not have to have been filed until July 31, 1976, and the preceding 4 complete calendar quarters with reference to a July 1, 1977, date would actually end March 31, 1977, since most returns for the last month of that 4 quarter period would not have to be filed until April 30, 1977. The calendar quarters are January through March, April through June, July through September and October through December.

g) Beginning October 1, 1993, a taxpayer who has an average monthly tax liability of $150,000 or more shall make all payments required by rules of the Department (see See 86 Ill. Adm. Code 750 "Payment of Taxes by Electronic Funds Transfer") by electronic funds transfer. Beginning October 1, 1994, a taxpayer who has an average monthly tax liability of $100,000 or more shall make all payments required by rules of the Department by electronic funds transfer. Beginning October 1, 1995, a taxpayer who has an average monthly tax liability of $50,000 or more shall make all payments required by rules of the Department by electronic funds transfer.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 130.540 Returns on a Transaction by Transaction Basis**

a) Who Must File Transaction Reporting Returns.
In addition, with respect to motor vehicles and aircraft (and implements of husbandry or special mobile equipment for which the purchaser intends to apply for an optional title), every retailer selling this kind of tangible personal property in Illinois shall file, with the Department, upon a form prescribed and supplied by the Department, a separate return for each such item of tangible personal property which the retailer sells.

b) Function And Contents Of Transaction Reporting Returns.

1) The transaction reporting return prescribed and supplied to retailers by the Department not only shall serve as such return, but also may serve as the dealer's invoice to the purchaser. Such forms will be numbered. The Department will keep a record of all of these forms which it supplies to a given retailer, and he is responsible for accounting to the Department for all such forms. If a transaction reporting return form should be spoiled, the retailer should mark it "voided" and send it back to the Department. Transaction reporting returns are not transferable by one retailer to another, but must be filed with or otherwise accounted for to the Department by the retailer to whom the particular forms are issued by the Department.

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2) Such transaction reporting return must show the name and address of the seller; the name and address of the purchaser; the amount of the selling price including the amount allowed by the retailer for traded-in property, if any; the amount allowed by the retailer for the traded-in tangible personal property, if any; the balance payable after deducting such trade-in allowance from the total selling price; the amount of tax due from the retailer with respect to such transaction; the amount of Use Tax collected from the purchaser by the retailer on such transaction (or satisfactory evidence that such tax is not due in that particular instance, if that is claimed to be the fact); the place and date of the sale; a sufficient identification of the property sold, and such other information as the Department may reasonably require.

c) Transaction Reporting Returns, When Due, Transaction Reporting Returns in Lieu of Monthly Returns

1) Such transaction reporting return shall be filed not later than 20 ~~30~~ days after the date of delivery of the item that is being sold, but may be filed by the retailer at any time sooner than that if he chooses to do so.

2) If a retailer's sales of tangible personal property are limited to sales of motor vehicles or aircraft, or both, so that all of his Retailers' Occupation Tax liability is required to be reported, and is reported, on such transaction reporting returns, and such retailer is not otherwise required to file monthly returns, such retailer need not file monthly returns.

3) If a retailer of motor vehicles or aircraft, or both, need not file a monthly return, such retailer shall be required to file returns on an annual basis.

d) Transmittal Of Transaction Reporting Return By Way Of Titling Or Registering Agency

The transaction reporting return and tax remittance or proof of exemption may be transmitted to the Department by way of the State agency with which, or State officer with whom, the tangible personal property must be titled or registered if the Department and such agency or State officer determine that this procedure will expedite the processing of applications for title or registration.

e) Submission Of Tax Or Proof Of Exemption With Transaction Reporting Returns -- Issuance of Use Tax Receipt Or Exemption Determination By Department of Revenue

With each such transaction reporting return, the retailer shall remit the proper amount of tax due (or shall submit satisfactory evidence that the sale is not taxable if that is the case), to the Department or its agents, whereupon the Department shall issue, in the purchaser's name, a Use Tax receipt (or a certificate of exemption if the Department is satisfied that the particular sale is tax exempt) which such purchaser may submit to the agency with which, or State officer with whom, he must title or register the tangible personal property that is involved in support of such purchaser's application for an Illinois certificate or other evidence of title or registration to such tangible personal property.



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f) Issuance of Title or Registration Where Retailer Fails Or Refuses To Remit Tax Collected By Retailer From User

No retailer's failure or refusal to remit tax hereunder shall preclude a user, who has paid the proper tax to the retailer, from obtaining his certificate of title or other evidence of title or registration upon satisfying the Department that such user has paid the proper tax (if tax is due) to the retailer.

g) Direct Payment Of Tax By User To Department On Intrastate Purchase Under Certain Circumstances.

If the user who would otherwise pay tax to the retailer wants the transaction reporting return filed and the payment of tax or proof of exemption made to the Department before the retailer is willing to take these actions and such user has not paid the tax to the retailer, such user may certify to the fact of such delay by the retailer and may (upon the Department being satisfied of the truth of such certification) transmit the information required by the transaction reporting return and the remittance for tax or proof of exemption directly to the Department and obtain his tax receipt or exemption determination, in which event the transaction reporting return and tax remittance (if a tax payment was required) shall be credited by the Department to the proper retailer's account with the Department, but without the 1.75% discount being allowed. When the user pays the tax directly to the Department as aforesaid, he shall pay the tax in the same amount and in the same form in which it would be remitted if the tax had been remitted to the Department by the retailer.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

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1) Heading of the Part: Service Occupation Tax

2) Code Citation: 86 Ill. Adm. Code 140

3) Section Numbers: Proposed Action:

| | |
|---|---|
| 140.401 | Amendment |
| 140.405 | Amendment |

4) Statutory Authority: 35 ILCS 115

5) A Complete Description of the Subjects and Issues Involved: Between the time this Part was originally drafted and the time this Part was proposed, P.A. 87-14 amended the Service Occupation Tax Act in a number of respects. This rulemaking amends Sections 140.401(a) and 140.405(a) & (b) to conform the quote of statutory language to the exact language of the Service Occupation Tax Act.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create a State Mandate, nor does it modify any existing State Mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Phillip Mc Collum
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, Illinois 62794
Phone: (217) 782-6996

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses affected: No new procedures are required that would impact small businesses.

B) Reporting, bookkeeping or other procedures required for compliance:



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None.

C) Types of professional skills necessary for compliance: None.

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Amendment(s) begins on the next page:

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NOTICE OF PROPOSED AMENDMENTS

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 140
SERVICE OCCUPATION TAX

SUBPART A: NATURE OF TAX



SUBPART B: DEFINITIONS



SUBPART C: BASE OF THE TAX



SUBPART D: TAX RETURNS



SUBPART E: INTERSTATE COMMERCE





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SUBPART F: REGISTRATION UNDER THE SERVICE OCCUPATION TAX ACT



SUBPART G: BOOKS AND RECORDS



SUBPART H: PENALTIES, INTEREST AND PROCEDURES



SUBPART I: WHEN OPINIONS FROM THE DEPARTMENT ARE BINDING



SUBPART J: COLLECTION OF THE TAX



SUBPART K: TIMELY MAILING TREATED AS TIMELY FILING AND PAYING -- MEANING OF DUE DATE WHICH FALLS ON SATURDAY, SUNDAY OR A HOLIDAY



SUBPART L: LEASED PORTIONS OF LESSOR'S BUSINESS SPACE



SUBPART M: USE OF EXEMPTION CERTIFICATES

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SUBPART N: CLAIMS TO RECOVER ERRONEOUSLY PAID TAX



SUBPART O: DISCONTINUATION OF A BUSINESS



SUBPART P: NOTICE OF SALES OF GOODS IN BULK



SUBPART Q: POWER OF ATTORNEY



AUTHORITY: Implementing the Service Occupation Tax Act [35 ILCS 115] and authorized by Section 39b30 of the Civil Administrative Code of Illinois [20 ILCS 2505/39b30].

SOURCE: Adopted May 21, 1962; amended at 3 Ill. Reg. 23, p. 161, effective June 3, 1979; amended at 3 Ill. Reg. 44, p. 198, effective October 19, 1979; amended at 4 Ill. Reg. 24, pp. 526, 536 and 550, effective June 1, 1980; amended at 5 Ill. Reg. 822, effective January 2, 1981; amended at 6 Ill. Reg. 2879, 2883, 2886, 2892, 2895 and 2897, effective March 3, 1982; codified at 6 Ill. Reg. 9326; amended at 9 Ill. Reg. 7941, effective May 14, 1985; amended at 11 Ill. Reg. 14090, effective August 11, 1987; emergency amendment at 12 Ill. Reg. 14419, effective September 1, 1988, for a maximum of 150 days; emergency expired January 29, 1989; amended at 13 Ill. Reg. 9388, effective June 6, 1989; amended at 14 Ill. Reg. 262, effective January 1, 1990; amended at 14 Ill. Reg. 15480, effective September 10, 1990; amended at 15 Ill. Reg. 5834, effective April 5, 1991; amended at 18 Ill. Reg. 1550, effective January 13, 1994; amended at 20 Ill. Reg. _____, effective _____.

SUBPART D: TAX RETURNS

**Section 140.401 Monthly Returns When Due -- Contents of Returns**



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a) Except as provided in Section 140.405 of this Subpart, on or before the twentieth ~~last~~ day of each calendar month, every serviceman registered with the Department is required to file a return with the Department covering the preceding month, stating the name of the person filing the return, his residence address, the address of his principal place of business and the address of his principal place of business in this State (if that is a different address) and each address from which he engages in said taxable business as a serviceman. Where the serviceman has more than one business registered with the Department under separate registrations, such serviceman shall file separate returns for each such separately registered business.

b) Information Required in Taxpayer's Return
A taxpayer's return shall disclose the following:
1) total tax base for the return period;
2) the amount of tax due;
3) the total of the tax and penalty;
4) such other information as the Department may require on the tax form.

c) 1.75% Allowance to Serviceman for Collecting State Tax
After entering his State Service Occupation Tax liability on the return, the serviceman may then deduct 1.75% of such liability as compensation for acting as a collector of the tax . The minimum discount, over the entire period of any given calendar year, for any single serviceman (if such serviceman has that much tax to remit) shall be $5.00 for such calendar year. This allowance against the State tax is available only when the tax is remitted with a return which is filed when due under the Act; it is not available in any case in which the tax is paid late .

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 140.405 Annual Tax Returns**

a) If the serviceman's average monthly tax liability to the Department does not exceed $200.00, the Department may authorize his returns to be filed on a quarter annual basis, with the return for January, February and March of a given year being due by April 20 ~~30~~ of such year; with the return for April, May and June of a given year being due by July 20 ~~31~~ of such year; with the return for July, August and September of a given year being due by October 20 ~~31~~ of such year, and with the return for October, November and December of a given year being due by January 20 ~~31~~ of the following year.

b) If the serviceman's average monthly tax liability to the Department does not exceed $50.00, the Department may authorize his returns to be filed on an annual basis, with the return for a given year being due by January 20 ~~31~~ of the following year.

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c) Such quarter annual and annual returns, as to form and substance, shall be subject to the same requirements as monthly returns.

(Source: Amended at 20 Ill. Reg. _____, effective _____)



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1) Heading of the Part: Service Use Tax

2) Code Citation: 86 Ill. Adm. Code 160

3) Section Numbers: Proposed Action:

160.135 Amendment

4) Statutory Authority: 35 ILCS 110

5) A Complete Description of the Subjects and Issues Involved: Between the time this Part was originally drafted and the time this Part was proposed, P.A. 87-14 amended the Service Use Tax Act in a number of respects. This rulemaking amends Section 160.135(a) to conform the quote of statutory language to the exact language of the Service Use Tax Act.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create a State Mandate, nor does it modify any existing State Mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Phillip McCollum
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, Illinois 62794
Phone: (217) 782-6996

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses affected: No new procedures are required that would impact small businesses.

B) Reporting, bookkeeping or other procedures required for compliance: None.

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C) Types of professional skills necessary for compliance: None.

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Amendment(s) begins on the next page:



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NOTICE OF PROPOSED AMENDMENTS

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 160
SERVICE USE TAX

Section
160.101 Nature of the Tax
160.105 Definitions
160.110 Kinds of Uses And Users Not Taxed
160.115 Collection Of The Service Use Tax By Servicemen
160.120 Receipt For The Tax
160.125 Special Information For Taxable Users
160.130 Registration Of Servicemen
160.135 Serviceman's Return
160.140 Penalties, Interest And Procedures
160.145 Incorporation Of Illinois Service Occupation Tax Regulations By Reference
160.150 Claims To Recover Erroneously Paid Tax--Limitations--Procedures
160.155 Disposition Of Credit Memoranda By Holders Thereof
160.160 Refunds
160.165 Interest

AUTHORITY: Implementing the Service Use Tax Act [35 ILCS 110] and authorized by Section 39b30 of the Civil Administrative Code of Illinois [20 ILCS 2505/39b30].

SOURCE: Adopted May 21, 1962; codified at 6 Ill. Reg. 9326; amended at 8 Ill. Reg. 8619, effective June 5, 1984; amended at 11 Ill. Reg. 5322, effective March 17, 1987; amended at 11 Ill. Reg. 9963, effective May 8, 1987; amended at 13 Ill. Reg. 9399, effective June 6, 1989; amended at 15 Ill. Reg. 5845, effective April 5, 1991; amended at 18 Ill. Reg. 1557, effective January 13, 1994; amended at 20 Ill. Reg. _____, effective _____.

**Section 160.135 Serviceman's Return**

a) Every serviceman required or authorized to collect the Service Use Tax must file a return each month by the twentieth ~~last~~ day of the month covering the preceding calendar month except when the serviceman is authorized to file tax returns on a quarterly or annual basis as hereinafter provided. The Department has combined the Service Use Tax return form, the Service Occupation Tax return form and the Use Tax return with the Retailers' Occupation Tax return form.

b) Where the sale of service is made under a conditional sales contract, or under any other form of sale wherein the payment of the principal sum, or a part thereof, is extended beyond the close of the return period for which the return is filed, the serviceman, in collecting the tax, may collect, for each return period, only the tax applicable

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to that part of the selling price actually received during such return period.

c) In his regular return, each serviceman shall also include the total amount of Service Use Tax due upon the selling price of tangible personal property transferred by him as an incident to a sale of service by a serviceman. Such serviceman shall remit the amount of such tax to the Department when filing such return.

d) In general, the provisions of Subpart D of the Service Occupation Tax (86 Ill. Adm. Code 140), (including the provisions pertaining to quarterly and annual tax returns, but not the provisions pertaining to annual information returns) shall apply to returns of servicemen under the Service Use Tax Act.

e) The serviceman who collects the Service Use Tax from his purchaser and who remits, as Service Use Tax, the amount so collected is allowed to deduct the 1.75% collection allowance or $5.00 per calendar year, whichever is greater, in the same manner as the serviceman is allowed to do under Subpart D of the Service Occupation Tax. (86 Ill. Adm. Code 150, Subpart D) Where a purchaser from a serviceman, however, does not pay the Service Use Tax to the serviceman, but pays it directly to the Department, that purchaser is not allowed to deduct any amount as a collection allowance.

(Source: Amended at 20 Ill. Reg. _____, effective _____)



DEPARTMENT OF REVENUE

NOTICE OF PROPOSED AMENDMENTS

1) Heading of the Part: Use Tax

2) Code Citation: 86 Ill. Adm. Code 150

3) Section Numbers: Proposed Action:

150.901 Amendment

4) Statutory Authority: 35 ILCS 105

5) A Complete Description of the Subjects and Issues Involved: Between the time this Part was originally drafted and the time this Part was proposed, P.A. 87-14 amended the Use Tax Act in a number of respects. This rulemaking amends Sections 150.901(a), (e) and (f) to conform the quote of statutory language to the exact language of the Use Tax Act.

6) Will this proposed rule replace an emergency rule currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this proposed amendment contain incorporations by reference? No

9) Are there any other proposed amendments pending on this Part? No

10) Statement of Statewide Policy Objectives: This rulemaking does not create a State Mandate, nor does it modify any existing State Mandates.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking: Persons who wish to submit comments on this proposed rule may submit them in writing by no later than 45 days after publication of this notice to:

Phillip McCollum
Associate Counsel
Illinois Department of Revenue
Legal Services Office
101 West Jefferson
Springfield, Illinois 62794
Phone: (217) 782-6996

12) Initial Regulatory Flexibility Analysis:

A) Types of small businesses affected: No new procedures are required that would impact small businesses.

B) Reporting, bookkeeping or other procedures required for compliance: None.

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C) Types of professional skills necessary for compliance: None.

13) Regulatory Agenda on which this rulemaking was summarized: July 1995

The full text of the Proposed Amendment(s) begins on the next page:



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NOTICE OF PROPOSED AMENDMENTS

TITLE 86: REVENUE
CHAPTER I: DEPARTMENT OF REVENUE

PART 150
USE TAX

SUBPART A: NATURE OF THE TAX



SUBPART B: DEFINITIONS



SUBPART C: KINDS OF USES AND USERS NOT TAXED



SUBPART D: COLLECTION OF THE USE TAX FROM USERS BY RETAILERS

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SUBPART E: RECEIPT FOR THE TAX



SUBPART F: SPECIAL INFORMATION FOR TAXABLE USERS



SUBPART G: REGISTRATION OF OUT-OF-STATE RETAILERS





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SUBPART H: RETAILERS' RETURNS



SUBPART I: PENALTIES, INTEREST AND PROCEDURES



SUBPART J: TRADED-IN PROPERTY



SUBPART K: INCORPORATION OF ILLINOIS RETAILERS' OCCUPATION TAX REGULATIONS BY REFERENCE



SUBPART L: BOOKS AND RECORDS



SUBPART M: CLAIMS TO RECOVER ERRONEOUSLY PAID TAX



AUTHORITY: Implementing the Use Tax Act [35 ILCS 105] and authorized by Section 39b28 of the Civil Administrative Code of Illinois [20 ILCS 2505/39b28].

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SOURCE: Adopted August 1, 1955; amended at 4 Ill. Reg. 24, p. 553, effective June 1, 1980; amended at 5 Ill. Reg. 5351, effective April 30, 1981; amended at 5 Ill. Reg. 11072, effective October 6, 1981; codified at 6 Ill. Reg. 9326; amended at 8 Ill. Reg. 3704, effective March 12, 1984; amended at 8 Ill. Reg. 7278, effective May 11, 1984; amended at 8 Ill. Reg. 8623, effective June 5, 1984; amended at 11 Ill. Reg. 6275, effective March, 20, 1987; amended at 14 Ill. Reg. 6835, effective April 19, 1990; amended at 15 Ill. Reg. 5861, effective April 5, 1991; emergency amendment at 16 Ill. Reg. 14889, effective September 9, 1992, for a maximum of 150 days; amended at 17 Ill. Reg. 1947, effective February 2, 1993; amended at 18 Ill. Reg. 1584, effective January 13, 1994; amended at 20 Ill. Reg. _____, effective _____.

SUBPART H: RETAILERS' RETURNS

**Section 150.901 When and Where to File**

a) Every retailer required or authorized to collect the Use Tax must file a return each month by the twentieth ~~last~~ day of the month covering the preceding calendar month, except when the retailer is authorized to file tax returns on a quarterly or annual basis as hereinafter provided. The Department has combined the retailers' Use Tax return form with the Retailers' Occupation Tax return form.

b) Where the tangible personal property is sold under a conditional sales contract or under any other form of sale wherein the payment of the principal sum or a part thereof is extended beyond the close of the return period for which the return is filed, the retailer, in collecting the tax, may collect, for each return period, only the tax applicable to that part of the selling price actually received during such return period.

c) In his regular monthly, quarterly or annual return, each retailer shall also include the total amount of Use Tax due upon the purchase price of tangible personal property (other than a motor vehicle or aircraft on which the tax is to be paid separately from the regular monthly, quarterly or annual return) purchased by him at retail from a retailer, but as to which such tax was not collected by the vendor from the retailer filing such return, and such retailer shall remit the amount of such tax to the Department when filing such return.

d) If the retailer files his Retailers' Occupation Tax returns on the gross sales basis, rather than on the gross receipts basis, he will be required to report the Use Tax information that he includes in his returns on the basis of gross sales (or on the basis of gross purchases in the case of reporting purchases for the retailer's use).

e) If the retailer's average monthly tax liability to the Department does not exceed $100.00, the Department may authorize his returns to be filed on a quarter annual basis, with the return for January, February and March of a given year being due by April 20 ~~30~~ of such year; with the return for April, May and June of a given year being due by July 20 ~~31~~ of such year; with the return for July, August and



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September of a given year being due by October 20 ~~31~~ of such year, and with the return for October, November and December of a given year being due by January 20 ~~31~~ of the following year.

f) If the retailer's average monthly tax liability to the Department does not exceed $50.00 ~~$20.00~~, the Department may authorize his returns to be filed on an annual basis, with the return for a given year being due by January 20 ~~31~~ of the following year.

g) Such quarter annual and annual returns, as to form and substance, shall be subject to the same requirements as monthly returns.

h) Notwithstanding any other provision in this Regulation concerning the time within which a retailer may file his return, in the case of any retailer who ceases to engage in a kind of business which makes him responsible for filing returns under this Regulation, such retailer shall file a final return under this Regulation with the Department not more than one month after discontinuing such business.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

STATE UNIVERSITIES CIVIL SERVICE SYSTEM

NOTICE OF PROPOSED AMENDMENT

1) Heading of the Part: State Universities Civil Service System

2) Code Citation: 80 Ill. Adm. Code 250

3) Section Numbers: Proposed Action:
250.10 Amendment
250.20 Amendment

4) Statutory Authority: Implementing and authorized by the State Universities Civil Service Act [110 ILCS 70]

5) A Complete Description of the Subjects and Issues Involved: Public Act 89-0004 restructures the board entities in higher education by eliminating the Board of Governors and the Board of Regents and establishes seven new boards.

6) Will this rulemaking replace any emergency rulemaking currently in effect? No

7) Does this rulemaking contain an automatic repeal date? No

8) Does this rulemaking contain incorporations by reference? No

9) Are there any other proposed rulemakings pending on this Part? No

10) Statement of Statewide Policy Objectives: Rulemaking does not affect units of local government.

11) Time, Place and Manner in which interested persons may comment on this proposed rulemaking:

Emil G. Peterson, Deputy Director
State Universities Civil Service System
1717 South Philo Road, Suite 24
Urbana, Illinois 61801
217/333-3150

12) Initial Regulatory Flexibility Analysis:
A) Types of small businesses, small municipalities and not for profit corporations affected: None
B) Reporting, bookkeeping or other procedures required for compliance: None
C) Types of professional skills necessary for compliance: None

13) Regulatory Agenda on which this rulemaking was summarized: This rule was not included on either of the 2 most recent agendas because: Pending litigation made the System unsure concerning how to proceed on this rulemaking.



STATE UNIVERSITIES CIVIL SERVICE SYSTEM

NOTICE OF PROPOSED AMENDMENT

The full text of the Proposed Amendment begins on the next page:

STATE UNIVERSITIES CIVIL SERVICE SYSTEM

NOTICE OF PROPOSED AMENDMENT

TITLE 80: PUBLIC OFFICIALS AND EMPLOYEES
SUBTITLE A: MERIT EMPLOYMENT SYSTEMS
CHAPTER VI: STATE UNIVERSITIES CIVIL SERVICE SYSTEM

PART 250
STATE UNIVERSITIES CIVIL SERVICE SYSTEM

Section
250.5 Definitions
250.10 Purpose, Adoption, and Amendment of Rules
250.20 The State Universities Civil Service System and its Divisions
250.30 The Classification Plan
250.40 Military Service Preference, Veterans Preference
250.50 Examinations
250.60 Eligible Registers
250.70 Nonstatus Appointments
250.80 Status Appointments
250.90 Probationary Period
250.100 Reassignments and Transfers
250.110 Separations and Demotions
250.120 Seniority
250.130 Review Procedures
250.140 Delegation of Authority and Responsibilities
250.150 Training
250.160 Suspension of Rules

AUTHORITY: Implementing and authorized by the State Universities Civil Service Act [110 ILCS 70].

SOURCE: Rules: State Universities Civil Service System, approved January 16, 1952, effective January 1, 1952; amended at 3 Ill. Reg. 13, p. 68, effective April 1, 1979; amended at 4 Ill. Reg. 10, p. 262, effective February 25, 1980; amended at 6 Ill. Reg. 2620, effective February 22, 1982; amended at 6 Ill. Reg. 7236, effective June 3, 1982; amended at 8 Ill. Reg. 4948 and 4950, effective March 29, 1984; codified at 8 Ill. Reg. 12936; amended at 8 Ill. Reg. 24732, effective December 6, 1984; amended at 9 Ill. Reg. 17422, effective October 23, 1985; amended at 11 Ill. Reg. 8942, effective May 8, 1987; amended at 12 Ill. Reg. 3457, effective February 1, 1988; amended at 12 Ill. Reg. 7079, effective October 7, 1988; amended at 13 Ill. Reg. 7324, effective May 1, 1989; amended at 13 Ill. Reg. 19427, effective February 6, 1990; amended at 18 Ill. Reg. 1901, effective January 21, 1994; amended at 20 Ill. Reg. _____, effective _____.

**Section 250.10 Purpose, Adoption, and Amendment of Rules**

a) Purpose.
The purpose of this Part is to give effect to the provisions of House Bill 831, as passed by the 67th General Assembly (an Act to create a



STATE UNIVERSITIES CIVIL SERVICE SYSTEM

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classified civil service system to be known as the State Universities Civil Service System). This Part shall be applied in accordance with the purposes of this Act as follows:

1) To establish a sound program of personnel administration and to promote efficiency and economy in the services performed by the Illinois Community College Board, Southern Illinois University, ~~the--universities-under-the-jurisdiction-of-the-Board-of-Regents,--the-colleges-and-universities-under-the-jurisdiction-of-the-Board-of-Governors-of-State-Colleges-and--Universities,--the--Board--of-Governors--of--State--Colleges--and--Universities,--the--Board-of-Regents--of--the--Regency--Universities--System,~~ University of Illinois, Chicago State University, Eastern Illinois University, Governors State University, Illinois State University, Northeastern Illinois University, Northern Illinois University, Western Illinois University, State Universities Civil Service System, State Universities Retirement System, the Illinois Student Assistance Commission ~~State-Scholarship--Commission~~, and the Board of Higher Education.
2) To provide equal opportunity for all, equal pay for equal work, and career opportunities comparable to those in business and industry, which will attract outstanding personnel to the State university service.

b) Adoption and Amendment of the Rules.
1) This Part shall be known as Civil Service Rules.
2) They become effective upon adoption by the Merit Board and ten days following their filing with the Secretary of State.
3) They may be amended at any time by majority vote of the Merit Board.

c) Policies and Procedures. The Merit Board shall adopt and enforce policies and procedures for carrying out the provisions of this Part and those of the statute ~~Statute~~. It shall supply appropriate forms for all personnel transactions required under this Part or the policies and procedures adopted under their authority.

(Source: Amended at 20 Ill. Reg. _____, effective _____)

**Section 250.20 The State Universities Civil Service System and its Divisions**

a) Classification and Allocation. All staff positions at the Illinois Community College Board, Southern Illinois University, ~~the universities-under-the-jurisdiction--of--the--Board--of--Regents,--the colleges--and--universities--under--the--jurisdiction--of-the-Board-of-Governors-of-State-Colleges-and-Universities,-the-Board--of--Governors-of--State--Colleges--and--Universities,--the--Board--of-Regents-of-the-Regency-Universities-System,~~ University of Illinois, Chicago State University, Eastern Illinois University, Governors State University, Illinois State University, Northeastern Illinois University, Northern

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Illinois University, Western Illinois University, State Universities Civil Service System, State Universities Retirement System, the Illinois Student Assistance Commission ~~State--Scholarship--Commission~~, and the Board of Higher Education, except those positions specifically exempted by Section 36e of the statute ~~Statute~~, are subject to classification functions as described in Section 250.30.

b) Other Personnel Functions. All positions in the institutions and agencies covered by the statute ~~Statute~~, except those exempted by Section 36e of the statute ~~Statute~~, are subject to the examination, appointment, and other personnel functions described under Sections 250.40 through 250.150 inclusive.

c) Designation of Persons to Act for Employer. Each employer governed by the statute ~~Statute~~ and by this Part shall, from time to time, as requested by the Director, file with the Director the name or names of those administrative officials of the employer who have been designated by the employer to act as its representative or representatives for the coordination of its acts and the exercise of its responsibilities in matters relating to the statute ~~Statute~~ and this Part.

(Source: Amended at 20 Ill. Reg. _____, effective _____)



DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Community Care Program

2) Code Citation: 89 Ill. Adm. Code 240

3) Section Numbers: Adopted Action:

240.436 New Section

4) Statutory Authority: 20 ILCS 105/4.01 (11) and 5.02.

5) Effective Date of Amendment(s): December 1, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this amendment contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: December 1, 1995

9) Notice of Proposal Published in Illinois Register: February 17, 1995: 19 Ill. Reg. 1363

10) Has JCAR issued a Statement of Objections to this amendment(s)? No

11) Difference(s) between proposal and final version:

As no comments were received in the public comment period, only a minor editorial change was made in response to staff comment.

12) Have all changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this amendment replace an emergency amendment currently in effect? No

14) Are there any proposed amendments pending on this Part? Yes

| Section | Proposed Action | Illinois Register Citation |
|---|---|---|
| 240.715 | Amendment | September 8, 1995 (19 Ill. Reg. 12563) |

15) Summary and Purpose of Amendment(s):

The purpose of this rulemaking is in response to the Whiteside v. Lindley, 92-CH-140, Consent Decree entered on March 9, 1994, in the Twentieth Judicial Circuit, in St. Clair County, Illinois. Plaintiffs challenged the Department's appeal process alleging that certain appeal policies and procedures violated a client's due process rights under the Fourteenth Amendment and State and Federal regulations when their Community Care Program services were either reduced or terminated.

DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS

In order to fulfill the agreement reached between the plaintiffs and the Department, the Department forwards this rule, specifying when an appeal may be cancelled.

16) Information and questions regarding this adopted amendment shall be directed to:

Ms. Pamela W. Balmer, Assistant
Office of General Counsel
Illinois Department on Aging
421 East Capitol Avenue #100
Springfield, Illinois 62701-1789
(217) 785-3346

The full text of the Adopted Amendment(s) begins on the next page:



DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER II: DEPARTMENT ON AGING

PART 240
COMMUNITY CARE PROGRAM

SUBPART A: GENERAL PROGRAM PROVISIONS



SUBPART B: SERVICE DEFINITIONS



SUBPART C: RIGHTS AND RESPONSIBILITIES



SUBPART D: APPEALS

DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS



SUBPART E: APPLICATION



SUBPART F: ELIGIBILITY



SUBPART G: NON-FINANCIAL REQUIREMENTS





DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS



SUBPART H: FINANCIAL REQUIREMENTS



SUBPART I: DISPOSITION OF DETERMINATION



SUBPART J: SPECIAL SERVICES

DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS



SUBPART K: TRANSFERS



SUBPART L: ADMINISTRATIVE SERVICE CONTRACT



SUBPART M: CASE COORDINATION UNITS AND VENDORS



SUBPART N: CASE COORDINATION UNITS



SUBPART O: PROVIDERS





DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS



SUBPART P: PROVIDER PROCUREMENT



SUBPART Q: CASE COORDINATION UNIT PROCUREMENT



SUBPART R: ADVISORY COMMITTEE



SUBPART S: RATES

DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS



SUBPART T: FINANCIAL REPORTING



AUTHORITY: Implementing Section 4.02 and authorized by Section 4.01(1) of the Illinois Act on the Aging [20 ILCS 105/4.02 and 4.01(1)].

SOURCE: Emergency rules adopted at 4 Ill. Reg. 1, p. 67, effective December 20, 1979, for a maximum of 150 days; adopted at 4 Ill. Reg. 17, p. 151, effective April 25, 1980; amended at 4 Ill. Reg. 43, p. 86, effective October 15, 1980; emergency amendments at 5 Ill. Reg. 1900, effective February 18, 1981, for a maximum of 150 days; amended at 5 Ill. Reg. 12090, effective October 26, 1981; emergency amendments at 6 Ill. Reg. 8455, effective July 6, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 14953, effective December 1, 1982; amended at 7 Ill. Reg. 8697, effective July 20, 1983; codified at 8 Ill. Reg. 2633; amended at 9 Ill. Reg. 1739, effective January 29, 1985; amended at 9 Ill. Reg. 10208, effective July 1, 1985; emergency amendments at 9 Ill. Reg. 14011, effective August 29, 1985, for a maximum of 150 days; amended at 10 Ill. Reg. 5076, effective March 15, 1986; recodified at 12 Ill. Reg. 7980; amended at 13 Ill. Reg. 11193, effective July 1, 1989; emergency amendments at 13 Ill. Reg. 13638, effective August 18, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 17327, effective November 1, 1989; amended at 14 Ill. Reg. 1233, effective January 12, 1990; amended at 14 Ill. Reg. 10732, effective July 1, 1990; emergency amendments at 15 Ill. Reg. 2838, effective February 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 10351, effective July 1, 1991; emergency amendments at 15 Ill. Reg. 14593, effective October 1, 1991 for a maximum of 150 days; emergency amendments at 15 Ill. Reg. 17398, effective November 15, 1991, for a maximum of 150 days; emergency amendments suspended at 16 Ill. Reg. 1744; emergency amendments modified in response to a suspension by the Joint Committee on Administrative Rules and reinstated at 16 Ill. Reg. 2943; amended at 15 Ill. Reg. 18568, effective December 13, 1991; emergency amendments at 16 Ill. Reg. 2630, effective February 1, 1992, for a maximum of 150 days; emergency amendments at 16 Ill. Reg. 2901, effective February 6, 1992, to expire June 30, 1992; emergency amendments at 16 Ill. Reg. 4069, effective February 28, 1992, to



DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS

expire June 30, 1992; amended at 16 Ill. Reg. 11403, effective June 30, 1992; emergency amendments at 16 Ill. Reg. 11625, effective July 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 11731, effective June 30, 1992; emergency rule added at 16 Ill. Reg. 12615, effective July 23, 1992, for a maximum of 150 days; modified at 16 Ill. Reg. 16680; amended at 16 Ill. Reg. 14565, effective September 8, 1992; amended at 16 Ill. Reg. 18767, effective November 27, 1992; amended at 17 Ill. Reg. 224, effective December 29, 1992; amended at 17 Ill. Reg. 6090, effective April 7, 1993; amended at 18 Ill. Reg. 609, effective February 1, 1994; emergency amendment at 18 Ill. Reg. 5348, effective March 22, 1994, for a maximum of 150 days; amended at 18 Ill. Reg. 13375, effective August 19, 1994; amended at 19 Ill. Reg. 9085, effective July 1, 1995; emergency amendments at 19 Ill. Reg. 10186, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 12693, effective August 25, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16031, effective November 20, 1995; added at 19 Ill. Reg. 16123, effective DEC 01 1995.

SUBPART D: APPEALS

**Section 240.436 Cancelling an Appeal**

a) The Department may cancel an appeal at any time during the appeal process for any of the following:
   1) Appellant's death;
   2) Appellant never received a notice of adverse action from the Department;
   3) Appellant is not a Community Care Program applicant/client;
   4) Appellant moves out of State;
   5) Appellant's appeal is upheld by the Department;
   6) Appellant/appellant's authorized representative does not submit a Notice of Appeal to the Department within 60 calendar days from the date the notice of adverse action was sent;
   7) Appeal is not related to any Community Care Program services; and/or
   8) Appeal is filed by an unauthorized representative.

b) The Department shall advise the appellant/authorized representative that the appeal is cancelled and formally closed, in writing, by certified mail, return receipt requested.

c) If the appellant/appellant's authorized representative does not agree with the reason for cancellation, the appellant/appellant's authorized representative must notify the Department, in writing, within 10 work days from receipt of the Notice of Cancellation.

d) If the appellant/appellant's authorized representative notifies the Department, in writing, within 10 work days from receipt of the Notice of Cancellation, the Department shall reinstate the appeal and continue the appeal process.

e) The Department shall furnish copies of the Notice of Cancellation to all interested parties to the appeal.

DEPARTMENT ON AGING

NOTICE OF ADOPTED AMENDMENTS

(Source: Added at 19 Ill. Reg. 16523, effective DEC 0 1 1995)



STATE BOARD OF EDUCATION

NOTICE OF ADOPTED RULES

1) Heading of the Part: Block Grant for School Improvement

2) Code Citation: 23 Ill. Adm. Code 160

3)

| Section Numbers: | Adopted Action: |
|---|---|
| 160.10 | New Section |
| 160.20 | New Section |
| 160.30 | New Section |
| 160.40 | New Section |

4) Statutory Authority: 105 ILCS 5/Art.1C

5) Effective Date of Rulemaking: December 5, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? The rules do not contain an incorporation by reference under Section 5-75 of the Illinois Administrative Procedure Act.

8) Date Filed in Agency's Principal Office: September 25, 1995

9) Notice of Proposal Published in Illinois Register: June 9, 19 Ill. Reg. 7485

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version: The first sentence in Section 160.30(a) had been expanded by adding a comma after the word "entitlement" and inserting the following text: "and shall notify districts of the final entitlement amount within 60 days after the amount of the appropriation is determined".

The word "rules" in Section 160.40(c) had been lower-cased.

A sentence has been added at the end of Section 160.40(e) to state, "Such reports shall describe expenditures of block grant funds for particular function, by categories such as salaries, benefits, purchased services, and supplies and materials."

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking: Public Act 88-555, enacted in 1994,

STATE BOARD OF EDUCATION

NOTICE OF ADOPTED RULES

combined into a block grant the funds previously available for staff development, outcomes and assessment, and second language program planning. The Act called for the State Board to adopt such rules as would be necessary for implementation of the block grant program.

Consistent with the intent of P.A. 88-555 to permit greater flexibility in the distribution and use of the money involved, the new Part 160 describes a simple application process for district to use. The rules also indicate the permissible uses of funds, describe the reports called for in the law, and set forth the other applicable terms of the grant.

16) Information and questions regarding these adopted rules shall be directed to:

Name: Warren Lionberger
Address: Grants Management
Illinois State Board of Education
100 North First Street
Springfield, Illinois 62777-0001
Telephone: (217) 782-3810

The full text of the Adopted Rule begins on the next page:



STATE BOARD OF EDUCATION

NOTICE OF ADOPTED RULES

TITLE 23: EDUCATION AND CULTURAL RESOURCES
SUBTITLE A: EDUCATION
CHAPTER I: STATE BOARD OF EDUCATION
SUBCHAPTER c: FINANCE

PART 160
BLOCK GRANT FOR SCHOOL IMPROVEMENT

Section
160.10 Purpose
160.20 Use of Funds
160.30 Application, Approval, and Funding
160.40 Terms of the Grant

AUTHORITY: Implementing and authorized by Article 1C of the School Code [105 ILCS 5/Art. 1C].

SOURCE: Adopted at 19 Ill. Reg. 16539, effective DEC 01 1995.

**Section 160.10 Purpose**

a) This Part establishes the procedures and criteria for approval of applications submitted by school districts to the State Board of Education for block grant funds as authorized by Article 1C of the School Code [105 ILCS 5/Art. 1C].
b) *The purpose of the block grant is to allow greater flexibility and efficiency in the distribution of certain funds to school districts and in the use of these funds for the improvement of educational services pursuant to locally established priorities* (Section 1C-2 of the School Code [105 ILCS 5/1C-2]).
c) Block grant programs shall include:
   1) staff development, including those programs and activities that meet the requirements of Sections 2-3.59 and 2-3.60 of the School Code;
   2) development of outcomes and assessments, including the activities called for in Sections 2-3.63 and 2-3.64 of the School Code;
   3) planning related to second language programs; and/or
   4) other priorities identified in a district's school improvement plan(s) (see Subpart A of the State Board's rules for Public Schools Evaluation, Recognition and Supervision, 23 Ill. Adm. Code 1).

**Section 160.20 Use of Funds**

a) Block grant funds provided pursuant to this Part shall be used only for one or more of the areas listed in Section 160.10(c) of this Part.
b) An amount not exceeding five percent of a district's block grant funds

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may be allocated for administrative costs directly related to one or more of the areas listed in Section 160.10(c) of this Part.

**Section 160.30 Application, Approval, and Funding**

Each public school district is entitled to receive an annual distribution of block grant funds. This shall be calculated by the State Board of Education on a per-pupil basis, based upon the total amount of funds appropriated for this purpose and the total enrollment in grades K-12 reflected in the Fall Enrollment and Housing Report for the immediately preceding year. The following procedures shall apply to the distribution of these funds.

a) The State Board of Education shall annually notify school districts of the estimated per-pupil amount of the block grant entitlement and shall notify districts of the final entitlement amount within 60 days after the amount of the appropriation is determined. The Board shall distribute application forms to school districts, allowing at least 45 days for districts to complete the applications and return them to the agency.

b) Each school district wishing to apply for block grant funds shall use the forms supplied by the State Board to furnish the following:
   1) A summary of the proposed use of the funds, indicating the types of activities to be funded;
   2) The total amount of the grant request, which shall be the estimated amount for which the district is eligible pursuant to this Section; and
   3) Such certifications and assurances as the State Board of Education may require.

c) State Board staff shall contact any school district whose application is incomplete, identifying such additional information as may be necessary for approval of the application.

d) Failure to comply with submission timelines may delay a school district's receipt of block grant funds.

e) The State Superintendent of Education shall approve each application that demonstrates compliance with Article 1C of the School Code and this Part.

**Section 160.40 Terms of the Grant**

a) Approved block grants will be paid to recipients in semiannual installments.

b) All grant funds shall be subject to the Illinois Grant Funds Recovery Act [30 ILCS 705].

c) Each school district applying for funds under this program must have a staff development plan on file, approved as required by Section 2-3.59 of the School Code and the State Board's rules at 23 Ill. Adm. Code 30 (Staff Development Plans and Programs).

d) Funds granted under this program must be used exclusively for the purposes listed in Section 160.10(c) of this Part and must be expended



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in accordance with the approved application and the grantee's policies and procedures related to such expenditures. Funds may only be expended for activities occurring during the grant period, which shall extend from July 1 of one year through September 15 of the following year.

e) Each school district receiving block grant funds shall submit the semiannual expenditure reports required by Section 1C-2 of the School Code, on forms supplied by the State Board of Education. Such reports shall describe expenditures of block grant funds for particular functions, by categories such as salaries, benefits, purchased services, supplies and materials.

f) To permit compliance with Section 1C-4 of the School Code [105 ILCS 5/1C-4], each school district shall annually provide to the State Superintendent of Education a year-end report including the activities funded; the numbers of staff members who received staff development services and the content areas involved, if applicable; and a description of the results of the funded activities.

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1) Heading of the Part: Electronic Transfer of Funds

2) Code Citation: 23 Ill. Adm. Code 155

3) Section Numbers: Adopted Action:

| | |
|---|---|
| 155.10 | New Section |
| 155.20 | New Section |
| 155.30 | New Section |
| 155.40 | New Section |
| 155.50 | New Section |
| 155.60 | New Section |
| 155.70 | New Section |

4) Statutory Authority: 105 ILCS 5/2-3.116 (see P.A. 89-641, effective September 9, 1994).

5) Effective Date of Rulemaking: December 5, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? The rules do not include an incorporation by reference under Section 5-75 of the Illinois Administrative Procedure Act.

8) Date Filed in Agency's Principal Office: September 25, 1995

9) Notice of Proposal Published in Illinois Register: July 7, 1995; 19 Ill. Reg. 8866

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version:

In Section 155.30(a)(8), the phrase "as on file with" has been changed to read, "which shall be a member of".

Section 155.30(c)(1) has been expanded by adding subsections (A) through (F) to enumerate specific agreements which must be stated by financial organizations.

A new subsection (3) has been added to Section 155.70(d), with subsections (1) and (2) slightly revised to accommodate it. The new subsection reads: "The transfer is rejected by the Comptroller's internal authorization system."

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes



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13) Will this rulemaking replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking: This new Part establishes the necessary procedures and requirements to implement the electronic transfer of funds pursuant to P.A. 88-641. Under these rules, school districts, other educational agencies, regional superintendents, and various individuals and service providers who are entitled to receive multiple payments from the State Board will be able to receive those payments electronically rather than by warrant.

16) Information and questions regarding these adopted rules shall be directed to:

Marcia Sailsbury
Funding and Disbursement Services
Illinois State Board of Education
100 North First Street
Springfield, IL 62777-0001
(217) 782-5256

The full text of the Adopted Rule begins on the next page:

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TITLE 23: EDUCATION AND CULTURAL RESOURCES
SUBTITLE A: EDUCATION
CHAPTER I: STATE BOARD OF EDUCATION
SUBCHAPTER c: FINANCE

PART 155
ELECTRONIC TRANSFER OF FUNDS

Section
155.10 Purpose
155.20 Eligible Participants
155.30 Initiation of Electronic Fund Transfers
155.40 Altering Electronic Fund Transfer Arrangements
155.50 Terminating Electronic Fund Transfer Arrangements
155.60 Responsibilities of the State Board of Education
155.70 Responsibilities of the Comptroller

AUTHORITY: Implementing and authorized by Section 2-3.116 of the School Code [105 ILCS 5/2-3.116 (see P.A. 88-641, effective September 9, 1994)].

SOURCE: Adopted at 19 Ill. Reg. 16538, effective DEC 05 1995.

**Section 155.10 Purpose**

This Part sets forth the procedural requirements for receiving funds via electronic transfer from the State Board of Education through the Office of the Comptroller pursuant to Section 2-3.116 of the School Code [105 ILCS 5/2-3.116 (see P.A. 88-641, effective September 9, 1994)].

**Section 155.20 Eligible Participants**

The payees listed below are eligible to receive funds via electronic transfer by following the procedures described in this Part, provided that they are expected to receive multiple payments of funds from the State Board of Education during any single fiscal year.

a) School districts
b) Regional superintendents of schools
c) Other education agencies such as educational cooperatives and joint agreements
d) Other payees such as universities, hospitals, community-based organizations, and day care centers
e) Individuals

**Section 155.30 Initiation of Electronic Fund Transfers**

a) To initiate electronic transfer of payments, the eligible participant shall provide the State Board of Education the following information,



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on a form prescribed by the State Board, as approved by the Comptroller. The form shall be signed and dated by an official authorized by the eligible participant.

1) The participant's nine-digit taxpayer identification number or Social Security number;
2) The participant's eleven-digit code assigned by the State Board to signify its region, county, district, and type;
3) The name in which payment is to be made;
4) The telephone number of the participant's main business office;
5) The street address, city, state, and zip code of the participant's main business office;
6) The name of the contact person for the electronic payment of funds;
7) A dated statement of authorization, signed by the chief executive officer of the entity, for all payments from the State Board of Education to be directed to the participant's account and for necessary debit entries and adjustments for errors to be initiated;
8) The name of the financial organization to which funds are to be electronically transferred, which shall be a member of the Federal Access or the Automated Clearing House (the nationwide network that provides the electronic payment system);
9) The street address, city, state, and zip code of the financial organization designated;
10) The title, type (checking or savings), and number of the account into which electronic transfers are to be made;
11) The nine-digit routing number of the financial organization designated;
12) The type of federal access agreement (governmental or commercial) held by the financial organization;
13) The expiration date of the organization's membership in the Automated Clearing House;
14) The branch designation of the financial organization, if applicable; and
15) The telephone number of the financial organization.

b) A copy of a deposit slip for the account into which funds are to be electronically transferred must be attached to the application form required under subsection (a) of this Section.

c) Each participant shall designate only one financial organization and one account number and shall make all necessary arrangements with the designated financial organization for the receipt of electronic fund transfers, including at least:

1) obtaining the organization's written agreement for electronic transfers, on a form supplied by the State Board of Education as approved by the Comptroller, which shall state that:
A) the financial organization agrees to receive and deposit sums for the participant,
B) the financial organization understands that its account

number will be included as additional identification on individual payment credits to the payee's account and that the payee has the right to cancel the authorization with the financial organization,

C) the financial organization agrees to forward all communications from the State of Illinois to the participant promptly, including the information contained in the addendum,

D) the financial organization agrees to return all payments that are not due to the participant,

E) the financial organization agrees to notify the State Board of Education promptly of any changes in its membership status as a Federal Access or Automated Clearing House (ACH) member institution), and

F) the financial organization may reserve the right to cancel the agreement by notice to the participant;

2) establishing the frequency and detail of transaction communications to ensure the participant's receipt of the 40-character descriptive entry called for in Section 155.60(c) of this Part, so that the origins of payments can be correctly identified.

d) Participants shall agree and accept that all payments of any kind from the State Board of Education shall be distributed only through electronic transfer.

e) Within thirty days after receipt of a complete application from an eligible participant, the State Board of Education will confirm the electronic transfer of funds for the participant by submission of a pre-note or zero fund transfer, i.e., a practice exercise in which no funds are transmitted.

f) After a successful pre-note transfer from the Comptroller, all payments of any kind to the participant will be made electronically.

**Section 155.40 Altering Electronic Fund Transfer Arrangements**

a) A participant wishing to designate a different account for the transfer of funds under this Part shall complete a new application form as called for in Section 155.30(a) of this Part and submit it to the State Board of Education at least thirty days before activation of transfers to the new account is desired.

b) Each change in an account will be confirmed via submission of a pre-note transfer as described in Section 155.30(e) of this Part.

c) After the State Board receives confirmation of an accurate pre-note fund transfer, all payments to the participant will be made to the newly designated account.

**Section 155.50 Terminating Electronic Fund Transfer Arrangements**

a) A participant wishing to terminate the electronic transfer of funds



shall submit a letter to the State Board of Education requesting such termination, signed by an official authorized to act on behalf of the participant and stating:

1) The participant's taxpayer identification number or Social Security number;

2) The code for the participant's region, county, district, and type;

3) The participant's name as submitted on the application for participation; and

4) The participant's address.

b) The State Board of Education shall cease electronic transfer of payments to a participant within thirty days after receipt of a letter requesting cancellation. Thereafter, all payments to the entity will be made by warrant. Warrants will be directed to the respective regional superintendents of schools or directly to payees as provided by law.

c) The State Board of Education and the Comptroller shall have the right to terminate an arrangement for the electronic transfer of funds for repeated problems or other interruptions in the processing of electronic fund transfers.

**Section 155.60 Responsibilities of the State Board of Education**

a) The State Board of Education shall follow the instructions given by an eligible participant in an application submitted pursuant to Section 155.30 or Section 155.40 of this Part, or in a request for termination submitted in accordance with Section 155.50 of this Part.

b) The State Board of Education shall transmit all information received from participants pursuant to this Part to the Comptroller, to ensure that participants receive transfers into the correct accounts.

c) The State Board of Education shall transmit to the Comptroller a forty-character descriptive entry for each payment authorized which, when communicated to the participant (see Section 155.70 of this Part), will describe the origin and nature of the payment.

d) The State Board of Education or the Comptroller may withhold payments to a participant as permitted or required by law. The State Board or the Comptroller, as applicable, shall provide written notice to the participant of its action.

e) The State Board of Education may withhold payments to a participant for failure to meet the terms of a contract.

f) The State Board of Education will handle all inquiries regarding electronic fund transfers, and only authorized personnel of the State Board shall forward unresolved inquiries to the Office of the Comptroller.

**Section 155.70 Responsibilities of the Comptroller**

a) The Comptroller will receive transmissions of information and

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instructions from the State Board of Education permitting the electronic transfer of funds.

b) In response to instructions received from the State Board, the Comptroller will transmit payments electronically to designated financial institutions. Each such transmission shall include the complete forty-character descriptive entry called for in Section 155.60(c) of this Part.

c) The Comptroller will notify the State Board of Education of all unsuccessful pre-note fund transfers.

d) The Comptroller will issue a warrant instead of transferring funds electronically when:

1) A designated financial institution rejects a transfer attempted pursuant to this Part;

2) An amount is subject to garnishment, offset, reduction, involuntary withholding, or other collection proceeding as provided by law (any amount payable after such action will be issued as a warrant); or

3) The transfer is rejected by the Comptroller's internal authorization system.



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1) Heading of the Part: Pupil Transportation

2) Code Citation: 23 Ill. Adm. Code 275

3) Section Numbers: Adopted Action:

| | |
|---|---|
| 275.30 | Repeal |
| 275.40 | Repeal |
| 275.50 | Repeal |
| 275.70 | Repeal |
| 275.80 | Amendment |

4) Statutory Authority: 105 ILCS 5/2-3.6

5)$ Effective Date of Rulemaking: December 5, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? The rules do not contain an incorporation by reference under Section 5-75 of the Illinois Administrative Procedure Act.

8) Date Filed in Agency's Principal Office: September 25, 1995

9) Notice of Proposal Published in Illinois Register: July 7, 1995; 19 Ill. Reg. 8872

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version: An incorrect citation to the *Illinois Register* has been corrected in the main source note (13 Ill. Reg 271 should be 13 Ill. Reg. 1532).

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? No changes were requested by JCAR during the second notice period, and no agreement letter was issued.

13) Will this rulemaking replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking: This set of amendments responds to P.A. 88-612. That Act transferred to the Secretary of State, effective July 1, 1995, most responsibilities associated with the issuance of permits to school bus drivers, causing the State Board to repeal most of its current rules on that subject. However, because the Act and the rules adopted by the Secretary of State at 92 Ill. Adm. Code 1035 do call for

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the Board's involvement in the approval ("certification") of bus driver instructors, Section 275.80 (Training) is being amended to set forth the standards for such approval.

16) Information and questions regarding these adopted amendments shall be directed to:

Marcia Sailsbury
Funding and Disbursement Services
Illinois State Board of Education
100 North First Street
Springfield, IL 62777-0001
(217) 782-5256

The full text of the Adopted Amendment begins on the next page:



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TITLE 23: EDUCATION AND CULTURAL RESOURCES
SUBTITLE A: EDUCATION
CHAPTER I: STATE BOARD OF EDUCATION
SUBCHAPTER h: TRANSPORTATION

PART 275
PUPIL TRANSPORTATION

Section
275.10 Definition of a School Bus
275.20 Routing
275.30 Annual Medical Examination and Certificate (Repealed)
275.40 Permit Application Process (Repealed)
275.50 Hearings (Repealed)
275.60 Vehicles Designed to Carry Nine Passengers or Less Excluding the Driver
275.70 Issuance of Permit (Repealed)
275.80 Training
275.90 Bus Safety Training for Students
275.100 Responsibility of Local School Boards
275.110 Operating a School Bus
275.120 Special Education

AUTHORITY: Implementing Section 27-26 and Article 29 of the School Code [105 ILCS 5/27-26 and Art. 29], Section 1-182 of the Illinois Vehicle Code [625 ILCS 5/1-182], Sections 6-104(b) and (d) and 6-106.1 of the Illinois Driver Licensing Law [625 ILCS 5/6-104(b) and (d) and 6-106.1], and Sections 11-406, 11-1202, and 11-1414 of the Illinois Rules of the Road [625 ILCS 5/11-406, 11-1202, and 11-1414] and authorized by Section 2-3.6 of the School Code [105 ILCS 5/2-3.6] and Section 12-812(b) of the Illinois Vehicle Equipment Law [625 ILCS 5/12-812(b)].

SOURCE: Illinois School Bus Transportation Rules and Regulations, amended April 18, 1974; rules repealed, new rules adopted at 2 Ill. Reg. 37, p. 201, effective September 25, 1978; codified at 7 Ill. Reg. 16507; amended at 13 Ill. Reg. 1532, effective January 23, 1989; emergency amendment at 14 Ill. Reg. 6411, effective April 17, 1990, for a maximum of 150 days; emergency expired September 14, 1990; amended at 14 Ill. Reg. 17954, effective October 18, 1990; amended at 19 Ill. Reg. 16545, effective DEC 05 1995.

**Section 275.30 Annual Medical Examination and Certificate (Repealed)**

~~a) All applicants for a school bus driver permit must demonstrate physical fitness to operate school buses by undergoing a medical examination, including tests for drug and alcohol use, conducted by a licensed physician within ninety (90) days of the date of application for such permit.~~

~~b) An applicant who within 90 days of the date of application has~~

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undergone a medical examination complying with Subpart E of 49 CFR 391 (1989) (no later amendments are incorporated herein) and/or drug tests complying with 49 CFR 40 (54 Fed. Reg. 49854, effective January 2, 1990, no later amendments are incorporated herein) shall be exempt from the corresponding requirements of this Section, provided that the applicant submits to the regional superintendent a copy of the federal "medical examiner's certificate" (49 CFR 391.41(d)) and/or a copy of the "drug testing custody and control form" (49 CFR 40.23(a)) signed by the responsible physician.

c) Except as provided in subsection (b), the medical examination for all applicants shall be performed in accordance with the provisions of this Section and 49 CFR 391.43(d). A form conforming to these requirements, as well as the medical examiner's certificate described in subsection (i), can be obtained from the regional superintendent of schools for the use of the examining physician.

d) Each applicant to be tested for drugs shall consent in writing to provide a urine specimen for this purpose as part of the applicant's annual medical examination and shall authorize the release of the results of such tests to the examining physician. Those persons responsible for collection of the specimen shall ensure that the specimen is not substituted, adulterated, or diluted by the applicant during the collection procedure. The specimen container shall be labeled to identify its source and shall be delivered to the testing laboratory by U.S. mail, personal delivery by the physician's staff, a professional messenger service, or by other means which preclude tampering with the specimen. Those persons responsible for collecting, processing, and testing the specimen shall maintain and be able to document a chain of custody for the specimen which ensures its integrity.

e) The specimen shall be tested for marijuana, cocaine, opiates, amphetamines and phencyclidine using the tests and standards for positive test results specified in 49 CFR 40.29(e) and (f). Testing shall be conducted by a laboratory certified by either the Illinois Department of Public Health pursuant to 77 Ill. Adm. Code 510, or the U.S. Department of Transportation pursuant to 49 CFR 40.

f) The laboratory shall report the test results only to the examining physician. The physician shall review confirmed positive test results in order to determine whether there is a legitimate medical explanation of legal drug use for each positive test result. The physician may, at his or her discretion, consult with another physician whose expertise in the area of substance abuse may, in the examining physician's judgment, be helpful in reviewing test results. The physician shall record his or her findings on the applicant's health certificate form. If the physician determines that there is no legitimate medical explanation for a positive test result for one or more of the tested drugs, the applicant shall be ineligible to receive a school bus driver permit.

g) Each applicant, as part of the annual medical examination, shall also



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be tested to assist the physician in determining whether the applicant has a current clinical diagnosis of alcoholism. The physician shall record on the examination form those tests which were administered, as well as the physician's findings as to whether the applicant has a current clinical diagnosis of alcoholism. An applicant with a current clinical diagnosis of alcoholism shall be ineligible for a school bus driver permit.

h) An applicant shall be considered physically qualified to operate a school bus only if he or she:

1) has no loss or impairment of a hand, finger, arm, foot, or leg which would interfere with the safe operation of a school bus, or has had such loss(es) or impairment(s) compensated for in a manner satisfactory to the examining physician;

2) has no established medical history or clinical diagnosis of diabetes mellitis currently requiring insulin for control which is likely to interfere with the ability to control and drive a school bus safely;

3) has no current clinical diagnosis of myocardial infarction, angina pectoris, coronary insufficiency, thrombosis, or any other cardiovascular disease of a variety known to be accompanied by syncope, dyspnea, collapse, or congestive cardiac failure;

4) has no established history or clinical diagnosis of a respiratory dysfunction likely to interfere with the ability to control and drive a school bus safely;

5) has no current clinical diagnosis of high blood pressure likely to interfere with the ability to control and drive a school bus safely;

6) has no established medical history or clinical diagnosis of rheumatic, arthritic, orthopedic, muscular, neuromuscular, or vascular disease likely to interfere with the ability to control and drive a school bus safely;

7) has no established medical history or clinical diagnosis of epilepsy or any other condition which is likely to cause loss of consciousness or any loss of ability to control and drive a school bus safely;

8) has no mental, nervous, organic or functional disease or psychiatric disorder likely to interfere with the ability to control and drive a school bus safely;

9) has distant visual acuity of at least 20/40 (Snellen) in each eye without corrective lenses, or visual acuity separately corrected to 20/40 (Snellen) or better with corrective lenses, distant binocular acuity of at least 20/40 (Snellen) in each eye with or without corrective lenses, field of vision of at least 70 degrees in the horizontal meridian in each eye, and the ability to recognize the colors of traffic signals and devices showing standard red, amber and green (i.e., no monocular individual may be considered qualified);

10) first perceives a forced whispered voice in the better ear at not

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less than 5 feet with or without a hearing aid or, if tested by use of an audiometric device, does not have an average hearing loss in the better ear greater than 40 decibels at 500 Hz, 1,000 Hz and 2,000 Hz with or without a hearing aid when the audiometric device is calibrated to American National Standard S24.5-1951;

ii) does not use amphetamines, cocaine, marijuana, opiates, phencyclidine, or any other mind altering drug or substance, or any prescribed drug that may interfere with the ability to operate a school bus safely; and

i2) has no current clinical diagnosis of alcoholism.

i) The examining physician's conclusion as to whether the person he/she examined is qualified to drive a school bus shall be recorded on a medical examiner's certificate with the following form:

MEDICAL EXAMINER'S CERTIFICATE

I certify that I have examined (driver's name (print)) in accordance with the provisions of Section 275.30 of 23 Ill. Adm. Code 275 (Pupil Transportation) and based upon the results of this examination, including the results of tests for alcohol and drug use required in Section 275.30, I find that he/she is

Qualified under the regulations
Qualified only when wearing corrective lenses
Qualified only when wearing a hearing aid
Not qualified under the regulations

A completed examination form for this person is on file in my office at (address).

_____
Date of Examination

_____
Name of Examining Doctor

_____
Signature of Examining Doctor

_____
Signature of Driver

_____
Address of Driver

j) One copy of the completed certificate is to be presented by the applicant to the regional superintendent in whose region services will be performed; one copy is to be retained by the applicant; and one copy is to be retained by the examining physician.

(Source: Repealed at 19 Ill. Reg. 16545, effective DEC 05 1995)

Section 275.40 Permit Application Process (Repealed)

a) Each applicant must first successfully complete an interview with the employing school district's designee to determine the acceptability of the applicant in terms of all provisions outlined in Ill. Rev. Stat. 1981, ch. 95 1/2, par. 6 106.1.

b) The individual desiring employment as a school bus driver must complete in an approvable form the "Application for Illinois School Bus Driver's Permit" and submit this with a fee of $2.00 and a completed Annual Health Certificate to the regional superintendent of the county wherein services will be performed.

c)

1) When a review by the Secretary of State's Office indicates that an applicant's driving history is acceptable under the provisions of Ill. Rev. Stat. 1981, ch. 95 1/2, par. 6 106.1, the applicant must show proficiency in the knowledge of school bus operation.

A) Applicant must pass a written examination administered by the Secretary of State's office with no more than three incorrect answers.

B) Applicant must show adequate proficiency in a road test administered by the Secretary of State's office in the class of vehicle to be used.

2) These tests must be successfully completed in three attempts and within 90 days prior to the date of application.

d) Reapplicants: Current school bus drivers need not be retested at the Secretary of State's Examining Station except when a change in license classification is necessary. An application submitted by a person who has held a valid Illinois School Bus Driver's Permit within 30 days of the date of application will be noted by the regional superintendent's office as a "Reapplication." The regional superintendent must review the past driving history prior to approval of the application.

e) Substitute Drivers: Those individuals who normally drive when regular school bus drivers are not available must have a permit. Athletic coaches, teachers, and other school employees who occasionally drive school buses which transport students to and from school or school related activities must be qualified and have a school bus driver's permit.

f) Out of State Applicants: Persons residing in a state other than Illinois who desire employment as school bus drivers, must obtain from the Office of the Secretary of State a properly classified operator's license restricted to driving a school bus in Illinois in addition to the operator's license held in the home state. In addition, the



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~~applicant---must--follow--the--procedure--outlined--for--new--resident applicants.~~

~~g) New-Resident-Applicants:--Persons-who-have-relocated-to-the--State--of Illinois--who--desire--employment--as--school-bus-drivers-must-provide documentation-from-the-former-state-of-residence-prior-to--application that--the--requirements--of--Ill.--Rev.--Stat.--1981,-ch.-95-1/2,-par. 6-106.1-(3),-(9)-and-(10)-have-been-met.--This-documentation--must--be attached--to-the-application-form-prior-to-proceeding-to-the-Secretary of-State's-Examining-Station.--The-applicant-must-follow-the-procedure outlined-for-new-applicants.~~

(Source: Repealed at 19 Ill. Reg. 16545, effective DEC 05 1995)

**Section 275.50 Hearings (Repealed)**

~~a) The--regional--superintendent-shall-conduct-a-hearing-for-an-applicant who-has-been-convicted-of-two-traffic-violations-within-two--years--of the-date-of-application.~~

~~b)~~

~~1) Hearings--for--the-purpose-of-reviewing-traffic-violation-history will-be-held-by-the-regional-superintendent-or-a-hearing--officer appointed-by-the-regional-superintendent.~~

~~2) A--hearing--shall--also--be--held--when-a-regional-superintendent suspends-or-revokes-a-School-Bus-Driver's-Permit--upon--receiving notice--that--a--school--bus-driver-has-been-convicted-of-traffic offenses-as-prescribed-in-Ill.-Rev.-Stat.-1981,-ch.-95-1/2,--par. 6-106.1.~~

~~c) The--hearing--officer--will--provide--a--finding--and--a--decision,-in duplicate,-after-the-hearing.~~

~~1) One-copy-is-to--be--retained--in--the--regional--superintendent's office.~~

~~2) One-copy-is-to-be-attached-to-the-application-prior-to-proceeding to--the--Secretary--of--State's--Examining--Station.--The-hearing officer-should-indicate-that-the-applicant-meets-the-requirements by-marking-the-appropriate-space--on--the--application--form--and initialing.~~

(Source: Repealed at 19 Ill. Reg. 16545, effective DEC 05 1995)

**Section 275.70 Issuance of Permit (Repealed)**

~~The-permit-form-shall-be-completed-in-duplicate-by-the-regional--superintendent only--after-the-requirements-of-Ill.-Rev.-Stat.-1981,-ch.-95-1/2,-par.-6-106.1, have-been-successfully-met-and-the-applicant-has-been-enrolled-in--the--initial training--course--addressed--in--Section--275.80-of-this-Part.--One-copy-of-the completed-permit-is-to-be-retained-by-the-regional-superintendent-and-the--card~~



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~~copy-is-to-be-kept-on-the-driver's-person.~~

(Source: Repealed at 19 Ill. Reg. 16545, effective DEC 05 1995)

**Section 275.80 Training**

Initial and refresher training is required of all school bus drivers by Section 6-106.1 of the Illinois Vehicle Code [625 ILCS 5/6-106.1]. Pursuant to Section 3-14.23 of the School Code [105 ILCS 5/3-14.23], Regional Superintendents of Schools are responsible for conducting training programs for school bus drivers, which programs shall be established by the State Board of Education and approved by the Secretary of State pursuant to the Secretary's rules for Transportation (92 Ill. Adm. Code 1035).

a) Section 1035.30 of the Secretary's rules requires the certification of bus driver instructors by the State Board of Education. The following standards shall apply to such certification.
   1) The person must be at least 21 years of age.
   2) The person must hold or have held an Illinois School Bus Driver's Permit, hold a current teaching certificate endorsed for driver education, or have the approval of the regional superintendent as having had other direct involvement in school bus transportation.
   3) The person must have completed the American Red Cross Basic First Aid Course or refresher course within the last three years.
   4) The person must have assisted a certified instructor with the conduct of an initial training course and have received a satisfactory evaluation of overall teaching performance.
   5) Certification of bus driver instructors shall be renewed annually. Renewal shall be sought by the regional superintendent of the region where services will be provided, with the permission of the individual(s) in question and using a form supplied by the State Board of Education. Renewal of certification shall be based on the criteria set forth in subsections (a)(1) through (a)(4) of this Section.

b) The State Board shall notify each regional superintendent of the certification status of all affected instructors in his or her region and of any deficiencies preventing the certification of any individual. The regional superintendent shall be responsible for notifying instructors of their status.

c) The regional superintendent shall be responsible for notifying the employers of all bus drivers who complete initial or refresher training courses.

~~a) Initial-training-as-well-as-annual-refresher-training-for--school--bus drivers--is--required--by--Ill.--Rev.--Stat.--1981,--ch.--95-1/2,-par. 6-106.1(a)(8).~~

~~b) Each-new-applicant-shall-be-enrolled-in-the-initial--classroom--course in--school--bus-driver-safety-offered-by-the-State-Board-of-Education.~~

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~~This course must be completed within 45 school days from the date of application.~~

~~c) The first aid portion of this course may be waived at the discretion of the respective regional superintendent where documentation is provided that the applicant has completed a certified course in first aid methods recognized by the State Board of Education within 12 months of the date of application.~~

~~d) Failure to complete the initial training course within 45 school days will require suspension of the holder's school bus driver's permit until evidence of successful course completion can be shown.~~

~~e) Prior to obtaining a school bus driver's permit, the employer shall certify to the regional superintendent that the applicant has been provided sufficient practical behind the wheel instruction to ensure that the applicant has exhibited proficiency in the safe and proper operation of a school bus.~~

~~f) Annual refresher courses are required for each school bus driver and shall consist of the following minimum requirements:~~

~~1) The regional superintendent is responsible for establishing and conducting the annual refresher training.~~

~~2) Refresher training courses shall be a minimum of two hours in length, one hour of which must cover first aid.~~

~~3) Refresher training must be taught by an instructor certified by the regional superintendent.~~

(Source: Amended at 19 Ill. Reg. 16545, effective DEC 0 5 1995)



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1) Heading of Part: Minimum Standards of Individual Accident and Health Insurance

2) Code Citation: 50 Ill. Adm. Code 2007

3) Section Number: Adopted Action:

| | |
|---|---|
| 2007.10 | Amended |
| 2007.20 | Amended |
| 2007.30 | Amended |
| 2007.40 | Amended |
| 2007.50 | Amended |
| 2007.60 | Amended |
| 2007.70 | Amended |
| 2007.80 | Amended |
| 2007.90 | Amended |

4) Statutory Authority: Implementing Section 355a and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/355a and 401].

5) Effective Date of Amendments: December 5, 1995

6) Does this Amendment contain an automatic repeal date? No

7) Does this Amendment contain incorporations by reference? No

8) Date filed in Agency's Principal Office: December 5, 1995

9) Notice of Proposal Published in Illinois Register: July 7, 1995, 19 Ill. Reg. 8886

10) Has JCAR issued a Statement of Objections to this Amendment? No

11) Difference(s) between proposal and final version:

a) Section 2007.10, on the fourth line of the DOI version change "... to make reasonable rules and regulations as may be necessary for making effective ..." to italicized language.

b) Section 2007.40(b), on line three of the DOI version strike "and Consent to ~~Future~~ Discontinuance of Future Use of Approved Policy Form."

c) Section 2007.50 in the definition of Hospital, on the seventh line of the DOI version strike the semicolon and add a colon. On lines 175 and 178 strike "or". Also on line 182 and "or" following the semicolon.

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d) Section 2007.50 in the definition of Physician, on the second line of the DOI version strike the colon and add a close quotation mark.

e) Section 2007.60(e)(2), on the first line delete the semicolon and add a comma. On the second line strike the semicolon. On line three of the DOI version delete the comma following "alcoholism". On the fourth line add a colon following "definition". On the fifth line change "jurisdiction" to "state". On the sixth line delete the comma, and on the last line add a semicolon at the end.

f) Section 2007.60(e)(5)(A), on the first line of the DOI version delete the comma.

g) Section 2007.60(e)(6), on the third line of the DOI version delete the comma. On the last line strike the period and add a semicolon.

h) Section 2007.60(e)(7), on the last line of the DOI version strike the period and add a semicolon.

i) Section 2007.60(e)(8), on the first line of the DOI version strike "or". On the second line change "workmen's" to "worker's".

j) Section 2007.60(g), on the fifth line of the DOI version add a comma following "e.g.". On the sixth line delete the comma.

k) Section 2007.60(i), on the seventh line of the DOI version retain the comma following "Director".

l) Section 2007.70(b)(2)(A), add a colon following "of".

m) Section 2007.70(b)(2)(A)(i), add a semicolon following "accommodations".

n) Section 2007.70(b)(2)(B), on the last line of the DOI version strike "and".

o) Section 2007.70(b)(2)(C), add a colon following "of".

p) Section 2007.70(b)(2)(C)(ii), on the last line of the DOI version strike the comma, add a semicolon and strike the semicolon at the end.

q) Section 2007.70(b)(2)(D), on the first line of the DOI version delete "subparagraph" add "subsection (b)(2)".

r) Section 2007.70(b)(4), two lines up from the bottom of the DOI version add "(31) day" following "thirty-one".

s) Section 2007.70(b)(5)(F), strike the semicolon and add a colon.



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t) Section 2007.70(b)(6), on the first line of the DOI version strike the comma.

u) Section 2007.70(b)(8), four lines up from the bottom of the DOI version change "subsection (c) or (d)~~;~~ below." to "subsection ~~(c)~~ (b)(8)(C) or ~~(d);~~ (D) below." On the last line change "(b) or (d)~~;~~ below." to (b)(8)(B) or ~~(d);~~ (D) below."

v) Section 2007.70(b)(8)(A)(iii), on the third line of the DOI version strike the comma.

w) Section 2007.70(b)(8)(A)(x), on the second line of the DOI version, following "a" add "minimum standard of specified disease coverage and is a". Also add "Skin cancer may only be excluded if it is in an additional benefit provision added to compliment underlying coverage not required by this Section".

x) Section 2007.70(b)(8)(C), on the tenth and twelfth line strike the parenthesis.

y) Section 2007.70(b)(8)(C)(vii), strike the "and" following the semicolon.

z) Section 2007.70(b)(8)(C)(x), strike the "and" following the semicolon.

aa) Section 2007.70(b)(8)(C)(xi), strike the period at the end of this subsection and add a semicolon.

bb) Section 2007.70(b)(8)(D)(i), on the first line strike "equal to one half" and add "of at least $100 for each day".

cc) Section 2007.70(b)(8)(D)(iii), on the eighth line of the DOI version, strike the period. On the ninth line, strike the period and add a period following the parenthesis.

dd) Section 2007.70(b)(10), on the first line of the DOI version add "(b)" following "subsection".

ee) Section 2007.70(b)(11), on the third line of the DOI version strike "Section 363".

ff) Section 2007.80(b)(1), on the fourth line of the DOI version, strike the hyphen and add "through".

gg) Section 2007.90(d)(1), on the first line of the DOI version, strike the comma.

12) Have all changes agreed upon by the agency and JCAR been made as indicated

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in the agreement letter issued by JCAR? Yes

13) Will this Amendment replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of rulemaking: The Department has amended this Part to make minor housekeeping changes and to add language to Section 2007.70 concerning specified disease limitations for skin cancer. In addition, we are allowing for specific exclusions which were not previously a part of this rule.

16) Information and questions regarding this adopted Amendment shall be directed to:

Cindy Colonius
Department of Insurance
320 West Washington
Springfield, IL 62767-0001
(217) 524-0663

The full text of the Adopted Amendment begins on the next page.



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TITLE 50: INSURANCE
CHAPTER I: DEPARTMENT OF INSURANCE
SUBCHAPTER z: ACCIDENT AND HEALTH INSURANCE

PART 2007
MINIMUM STANDARDS OF INDIVIDUAL ACCIDENT
AND HEALTH INSURANCE

Section


AUTHORITY: Implementing Section 355a and authorized by Section 401 of the Illinois Insurance Code [215 ILCS 5/355a and 401].

SOURCE: Adopted at 2 Ill. Reg. 30, p. 41, effective August 1, 1978; amended at 4 Ill. Reg. 45, p. 102, effective March 1, 1981; amended at 6 Ill. Reg. 7072, effective May 27, 1982; codified at 7 Ill. Reg. 10591; amended at 12 Ill. Reg. 6921, effective April 1, 1988; amended at 15 Ill. Reg. 7658, effective May 7, 1991; amended at 19 Ill. Reg. 16555 effective DEC 05 1995.

**Section 2007.10 Authority**

This Part is issued by the Director of Insurance pursuant to Section 401 of the Illinois Insurance Code [215 ILCS 5/401] ~~{Ill. Rev. Stat. 1989, ch. 73, par. 1013}~~ which empowers the Director *". . . to make reasonable rules and regulations as may be necessary for making effective . . ."* ~~". . . to make reasonable rules and regulations as may be necessary for making effective . . ."~~ the insurance laws of this State. This Part implements Section 355a of the Illinois Insurance Code [215 ILCS 5/355a] ~~{Ill. Rev. Stat. 1989, ch. 73, par. 967a}~~.

(Source: Amended at 19 Ill. Reg. 16555, effective DEC 05 1995)

**Section 2007.20 Purpose**

The purpose of this Part is to define terms, establish minimum standards for benefits, prohibit certain policy provisions and require ~~certain~~ disclosure

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provisions and replacement procedures in relation to policies of individual accident and health insurance.

(Source: Amended at 19 Ill. Reg. 16555, effective DEC 05 1995)

**Section 2007.30 Applicability**

a) This Part shall apply to all individual accident and health insurance policies except that it shall not apply to individual policies issued pursuant to a conversion privilege under a policy of group or individual insurance when such individual policy includes provisions which are inconsistent with the requirements of this Part ~~part~~, nor to policies being issued to employees or members as additions to franchise plans in existence prior to July 17, 1978.

b) The requirements contained in this Part shall be in addition to any other applicable regulations ~~Rules~~.

(Source: Amended at 19 Ill. Reg. 16555, effective DEC 05 1995)

**Section 2007.40 Revision of Noncomplying Policy Form and Subscriber Contracts Certificate of Compliance Required**

a) Any policy as defined in Section 355a of the Illinois Insurance Code [215 ILCS 5/355a] previously filed and approved by the Director need not be refiled if such policy is in compliance with the requirements of this Part. Any previously approved policy which does not comply with the requirements of this Part shall ~~must~~ be amended by rider or revised and resubmitted in duplicate with a duplicate letter of transmittal.

b) All forms and contracts required to be revised and resubmitted by this Part shall be accompanied by a Certificate of Compliance and Consent to ~~Future~~ Discontinuance of Future Use of Approved Policy Form as required by 50 Ill. Adm. Code 916.Exhibit A.

(Source: Amended at 19 Ill. Reg. ~~16555~~, effective DEC 05 1995)

**Section 2007.50 Definitions**

Except as provided hereafter, no individual accident or health insurance policy delivered or issued for delivery to any person in this State shall contain definitions respecting the matters set forth below unless such definitions comply with the requirements of this Section.

~~"Accident" and "Accidental Injury"~~
"Accident" and "Accidental Injury" shall be defined to employ "result"



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language and shall not include words which establish an accidental means test or use words such as "external," "violent," "visible" or similar words of description or characterization. The definition shall not be more restrictive than the following: "Injury or injuries, for which benefits are provided, means accidental bodily injuries sustained by the insured person which are the direct cause of loss, independent of disease cause of loss, independent of disease or bodily infirmity and occurring while the insurance is in force."

(AGENCY NOTE: The fact that the injury combined with other factors to produce the loss does not necessarily relieve the insurer of liability. Each claim must be judged on the basis of its particular facts and in light of the court decisions, to determine whether the injury is to be considered as the cause of the loss.)

Such definition may provide that injuries shall not include injuries for which benefits are provided under any workers' compensation, employer's liability or similar law, motor vehicle no-fault plan, unless prohibited by law, or injuries occurring while the insured person is engaged in any activity pertaining to any trade, business, employment, or occupation for wage or profit.

"Convalescent Nursing Home," "Extended Care Facility," or "Skilled Nursing Facility" shall be defined in relation to its status, facilities and available services.

A definition of such home or facility shall not be more restrictive than one requiring that it:

be operated pursuant to law;

be approved for payment of Medicare benefits or be qualified to receive such approval, if so requested;

be primarily engaged in providing, in addition to room and board accommodations, skilled nursing care under the supervision of a duly licensed physician;

provide continuous 24 hours a day nursing service by or under the supervision of a registered graduate professional nurse (R.N.); and

maintains a daily medical record of each patient.

The definition of such home or facility may provide that such term shall not be inclusive of:

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any home, facility or part thereof used primarily for rest;

a home or facility for the aged or for the care of drug addicts or alcoholics; or

a home or facility primarily used for the care and treatment of mental diseases or disorders, or custodial or educational care.

"Home Health Care Agency" shall not be defined more restrictively than a public agency or private organization that provides skilled nursing services and meets the following requirements:

It is primarily engaged in providing home health care services;

Its policies are established by a group of professional personnel (including at least one physician and one registered nurse (R.N.));

Supervision of home health care services is provided by a physician or a registered nurse (R.N.);

It maintains clinical records on all patients; and

It has a full time administrator.

"Home Health Care" shall not be defined more restrictively than skilled nursing care or services provided to a person at a residence according to a plan of treatment for illness or infirmity prescribed by a physician. Such services shall include, but are not limited to, the following:

Part time and intermittent skilled nursing services - Services given to a patient at least once every 60 days or as frequently as a few hours per day, several days per week.

Therapeutic Services:

Physical Therapy;

Occupational Therapy;

Speech and Hearing Therapy;

Medical social services, medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services and laboratory services to the extent such charges or costs would have been covered under the policy if the insured person had



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remained in the hospital.

"Hospital" may be defined in relation to its status, facilities and available services or to reflect its accreditation by the Joint Commission on Accreditation of Hospitals.

The definition of the term "hospital" shall not be more restrictive than one requiring that the hospital:

be an institution operated pursuant to the law; and

be primarily and continuously engaged in providing or operating medical and diagnostic facilities, with major surgical facilities either on its premises or in facilities available to the hospital on a prearranged basis, under the supervision of a staff of duly licensed physicians, for the medical care and treatment of sick or injured persons on an in-patient basis for which a charge is made; and

provide 24 hours nursing service by or under the supervision of registered graduate professional nurses (R.N.'s).

The definition of the term "hospital" may state that such term shall not be inclusive of:

convalescent, rest, or nursing homes or facilities; or

facilities primarily affording custodial or educational care or care or treatment for persons suffering from mental diseases or disorders; or

facilities for the aged, mentally ill, drug addicts or alcoholics (except for a unit of a hospital dedicated to the treatment of drug addicts or alcoholics or the mentally ill); or

any military or veterans hospital or soldiers home or any hospital contracted for or operated by any national government or agency thereof for the treatment of members or ex-members of the armed forces, except for services rendered on an emergency basis where a legal liability exists for charges made to the individual for such services.

"Medicare" shall be defined in any hospital, surgical or medical expense policy which relates its coverage to eligibility for Medicare or Medicare benefits. Medicare may be substantially defined as "The Health Insurance for the Aged Act, Subchapter XVIII of the Social Security Amendments of 1965 as then constituted or later amended (42

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U.S.C. 1395 et seq.)," or "Title I, Part I of Public Laws 89-97, as Enacted by the Eighty-Ninth Congress of the United States of America and popularly known as the Health Insurance for the Aged Act (42 U.S.C. 395 et seq.), as then constituted and any later amendments or substitutes thereof" or words of similar import.

"Mental or Nervous Disorders" shall not be defined more restrictively than a definition including neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

"Nurses" may be defined so that the description of nurse is restricted to a type of nurse, such as registered graduate professional nurse (R.N.), a licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.). If the words "nurse," "trained nurse" or "registered nurse" are used without specific instruction, then the use of such terms requires the insurer to recognize the services of any individual who qualifies under such terminology in accordance with the applicable statutes or administrative rules of the licensing or registry board of the state.

"One period of confinement" or "continuous hospital confinement" means consecutive days of in-hospital service received as an in-patient, or successive confinements when discharge from and readmission to the hospital occurs within a period of time not more than 90 days or three times the maximum number of days of in-hospital coverage provided by the policy to a maximum of 180 days, whichever is greater.

"Partial Disability" shall be defined in relation of the individual's inability to perform one or more, but not all, of the "major," "important," or "essential" duties of employment or occupation or may be related to a percentage of time worked, to a specified number of hours or to compensation. Where a policy provides total disability benefits and partial disability benefits, only one elimination period may be required.

"Physician" may be defined by including words such as "duly qualified physician" or "duly licensed physician." The use of such terms requires an insurer to recognize and to accept, to the extent of its obligation under the contract, all providers of medical care and treatment when such services are within the scope of the provider's licensed authority and are provided pursuant to applicable laws dealing with physician licensure.

"Residual Disability" shall be defined in relation to the individual's reduction in earnings and may be related either to the inability to perform some part of the "major," "important," or "essential" duties of employment or occupation, or to the inability to perform all usual business for as long as is usually required. A policy which provides



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for residual disability benefits may require a qualification period, during which the insured must be continuously totally disabled before residual disability benefits are payable. The qualification period for residual benefits may be longer than the elimination period for total disability. In lieu of the term "residual disability," the insurer may use "proportionate disability" or other term of similar import which in the opinion of the Director adequately and fairly describes the benefit.

"Sickness" shall not be defined to be more restrictive than the following: "Sickness means sickness or disease of an insured person which first manifests itself after the effective date of insurance and while the insurance is in force." A definition of sickness may provide for a probationary period which will not exceed thirty (30) days from the effective date of the coverage of the insured person. The definition may be further modified to exclude sickness or disease for which benefits are provided under any workers' compensation, occupational disease, employer's liability or similar law.

"Total Disability"

A general definition of total disability cannot be more restrictive than one requiring the individual to be totally disabled from engaging in any such employment or occupation which he could, giving due consideration of his education, training or experience be reasonably expected to engage in and is not in fact engaged in any employment or occupation for wage or profit.

Total disability may be defined in relation to the inability of the person to perform duties but may not be based solely upon an individual's inability to:

Perform "any occupation whatsoever," "any occupational duty," or "any and every duty of his occupation,"

Engage in any training or rehabilitation program.

An insurer may specify the requirement of the complete inability of the person to perform all of the substantial and material duties of his regular occupation or words of similar import. An insurer may require care by a physician other than the insured or a member of the insured's immediate family.

When through a specific provision of a policy, disability coverage is provided to a retired person, such definition shall not require more than the insured be completely unable to engage in the normal activities of a retired person of like age and good health.

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(Source: Amended at 19 Ill. Reg. 16555, effective DEC 05 1995)

**Section 2007.60 Prohibited Policy Provisions**

a) Except as provided in Section 2007.50 definition of "sickness", no policy shall contain provisions establishing a probationary or waiting period during which no coverage is provided under the policy subject to the further exception that a policy may specify a probationary or waiting period not to exceed six (6) months for specified diseases or conditions and losses resulting therefrom for hernia, varicose veins, adenoids, appendix and tonsils. However, the permissible six (6) months exception shall not be applicable where such specified diseases or conditions are treated on an emergency basis. Accident policies shall not contain a probationary or waiting period.

b) No policy or rider for additional coverage may be issued as a dividend unless an equivalent cash payment is offered to the policyholder as an alternative to such dividend policy or rider. No such dividend policy or rider shall be issued for an initial term of less than six (6) months.

c) A disability policy, hospital confinement indemnity policy or specified disease policy may contain a "return of premium" or "cash value benefit" so long as:
   1) The policy provides for a return of 100% of all premiums paid less the claims incurred by the time the insured attains age 65. A percentage of less than 100%, but greater than 50%, is permissible if the "return of premium" or "cash value benefit" has been in force for 10 years or less;
   2) The policy contains a reasonable nonforfeiture benefit and provides for the value to be paid automatically upon lapse or death;
   3) The surrender value percentages are not less than those calculated assuming 1958 Commissioners Standard Ordinary Mortality, 5% interest and 5 year preliminary term;
   4) An acceptable method of reserving is approved by the Director concurrent with approval of the policy. Reserves should exceed or equal the cash value at all durations;
   5) The surrender value percentages are calculated assuming a zero percent future claim offset;
   6) The surrender value percentages are defined for all policy years (surrender value percentages may be shown only for the first twenty policy years, but under these conditions the contract shall ~~must~~ define the method used to determine the surrender value percentages after the twentieth contract year);
   7) The interim surrender value percentages are defined when premiums are paid within a contract year;
   8) The policy does not tie the return of premium to anything less than 100% of the premiums paid less claims paid.



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d) Accident and Health policies shall not contain provisions excluding coverage for:
   1) Confinement in a hospital operated by a Federal, State or Local Government;
   2) Charges for medical services provided by a Federal, State or Local Government;
   where a liability exists for charges made to or on behalf of the insured or covered dependents.

e) No policy shall limit or exclude coverage by type of illness, accident, treatment or medical condition, except as follows:
   1) Preexisting conditions or diseases;
   2) Mental or emotional disorders, alcoholism, intoxication and drug addiction~~;~~ (policies which exclude benefits for alcoholism or intoxication shall provide the following definition: "That which is defined and determined by the laws of the state where the loss or cause of the loss was incurred");
   3) Pregnancy, except for complications of pregnancy;
   4) Rehabilitative care, except that where benefits, in whole or in part, would be payable for such care under the terms of coverage, those benefits shall ~~may~~ not be denied on the basis that such care or treatment was provided, in whole or in part, in a rehabilitation institution, if such institution was a fully accredited hospital as defined in Section 2007.50 of this Part at the time care or treatment was provided;
   5) Injury, illness, treatment or medical condition arising out of:
      A) war or act of war (whether declared or undeclared); participation in a felony, riot or insurrection; service in the armed forces or units auxiliary thereto,
      B) suicide (sane or insane), attempted suicide or intentionally self-inflicted injury,
      C) aviation,
      D) with respect to short-term nonrenewable policies, interscholastic sports;
   6) Cosmetic surgery, except that "cosmetic surgery" shall not include reconstructive surgery when such service is incidental to or follows surgery resulting from trauma, infection or other diseases of the involved part;~~;~~
   7) Foot care in connection with corns, calluses, flat feet, fallen arches, weak feet, chronic foot strain, or symptomatic complaints of the feet;~~;~~
   8) Benefits provided under Medicare, ~~or~~ any state or federal worker's ~~workmen's~~ compensation, employer's liability or occupational disease law, or any motor vehicle no-fault law; services rendered by employees of hospitals, laboratories or other institutions; services performed by a member of the covered person's immediate family; and services for which no charge is normally made in the absence of insurance;~~;~~
   9) Dental care or treatment;

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10) Eye glasses, hearing aids and examination for the prescription or fitting thereof;
11) Rest cures, custodial care, transportation and routine physical examinations;
12) Territorial limitations;~~.~~
13) Sex change surgery or surgical sterilization;
14) Tests or x-rays not related to diagnosis;
15) Infertility;
16) Drugs, therapies, procedures or treatments which are not medically necessary;
17) Weight reduction procedures, treatments or classes (except for morbid obesity);
18) Smoking cessation classes or patches.

f) No provision of this Part shall prohibit the use of any policy provision which is required or permitted by statute. Other provisions of this Part shall not impair or limit the use of waivers to exclude, limit or reduce coverage or benefits for specifically named or described preexisting diseases, physical condition or extra hazardous activity. Where waivers are required as a condition of issuance, renewal or reinstatement, signed acceptance by the insured is required unless on initial issuance the full text of the waiver is contained either on the first page or specification page of the policy, or unless notice of the waiver appears on the first page or specification page.

g) No policy, rider or endorsement providing benefits for loss due to an accident or accidental injury shall contain a provision or clause limiting, reducing or excluding liability for a loss resulting from purely accidental circumstances (e.g., involuntary or unintentional ingestion of poison or inhalation of poisonous gases or fumes). This restriction shall not preclude the exclusion of loss due to suicide or attempted ~~attempt~~ suicide ~~thereat~~ by properly drawn language nor shall it preclude approval of a benefit for loss from defined accidents, such as travel, sport and student accident insurance.

h) No policy, rider or endorsement shall limit or exclude coverage for illness, accident, treatment or medical condition by using a general exclusion for complications arising from a covered condition or the treatment of a covered condition. This restriction shall not preclude the exclusion of loss due to such complications which are specifically named.

i) Policy provisions precluded in this Section shall not be construed as a limitation on the authority of the Director to disapprove other policy provisions in accordance with ~~Insurance Code~~ Section 143~~,~~(1) of the Illinois Insurance Code [215 ILCS 5/143(1)]~~,~~ ~~(Ill. Rev. Stat. 1989, ch. 73, par. 755(1))~~, which, in the opinion of the Director, are unjust, unfair, or unfairly discriminatory to the policyholder, beneficiary, or any person insured under the policy.

(Source: Amended at 19 Ill. Reg. 16555, effective



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DEC 0 5 1995 )

**Section 2007.70 Accident and Health Minimum Standards for Benefits**

a) The following minimum standards for benefits are prescribed for the categories of coverage noted in the following subsection. No individual policy of accident and health insurance shall be delivered or issued for delivery in this State which does not meet the required minimum standards for the specified categories unless the Director finds that such policies are Limited Benefit Health Insurance in which case ~~and~~ the Outline of Coverage shall comply ~~complies~~ with ~~the appropriate outline in~~ Section 2007.80(c) of this Part.

b) Nothing in this Section shall preclude the issuance of any policy combining two or more categories of coverage as set forth in Section 355a~~,~~ ~~subsection~~(4)~~,~~ of the Illinois Insurance Code [215 ILCS 5/355(a)(4)].

1) General Rules

A) A "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" policy shall not provide for termination of coverage of the spouse solely because of the occurrence of an event specified for termination of coverage of the insured, other than nonpayment of premium. The policy shall provide that in the event of the insured's death the spouse of the insured, if covered under the policy, shall become the insured.

B) The terms "noncancellable," "guaranteed renewable," or "noncancellable and guaranteed renewable" shall not be used without further explanatory language in accordance with the disclosure requirements of Section 2007.80(a)(1) of this Part. The terms "noncancellable" or "noncancellable and guaranteed renewable" shall be defined as in 50 Ill. Adm. Code 2003.

C) In a family policy covering both husband and wife, the age of the younger spouse shall ~~must~~ be used as the basis for meeting the age and durational requirements of the definitions of "noncancellable" or "guaranteed renewable." However, this requirement shall not prevent termination of coverage of the older spouse upon attainment of the stated age limit (e.g., age 65) so long as the policy may be continued in force by ~~as to~~ the younger spouse to the age or for the durational period as specified in said definition.

D) If a policy contains a status-type military service exclusion of a provision which suspends coverage during military service, the policy shall provide, upon receipt of written request, for refund of premiums as applicable to such person on a pro rate basis.

E) Policies providing normal pregnancy benefits shall provide that in the event the insurer cancels or refuses to renew

the policy there shall be an extension of benefits for ~~as to~~ pregnancy commencing while the policy is in force and at the same level for which benefits would have been payable had the policy remained in force.

F) Policies providing convalescent or extended care benefits following hospitalization shall not condition such benefits upon admission to the convalescent or extended care facility within a period of less than fourteen (14) days after discharge from the hospital.

G) Any medical, surgical or other expense benefit for the recipient insured in a transplant operation may specify the limits for such specific benefit relating to donors, or shall provide reimbursement of such expense of the live donor to the extent that such benefits remain and are available under the recipient's policy, after benefits for the recipient's own expenses have been paid.

H) A policy may contain a provision relating to recurrent disabilities provided, however, that no such provision shall specify that a recurrent disability be separated by a period greater than six (6) months.

I) Any pre-existing condition exclusion shall ~~must~~ be administered in accordance with 50 Ill. Adm. Code 2005. When a definition of preexisting condition(s) is required by 50 Ill. Adm. Code 2005.50, for purposes of readability, it may be summarized in the appropriate policy provision by a definition reading substantially as follows:

"A pre-existing illness (condition) means any condition that was diagnosed or treated by a physician within 24 months prior to the effective date of the coverage, or produced symptoms within 12 months prior to the effective date of coverage that would have caused an ordinarily prudent person to seek medical diagnosis or treatment."

J) Accidental death and dismemberment benefits shall be payable if the loss occurs within ninety (90) days from the date of the accident, irrespective of total disability. Disability income benefits, if provided, shall not require the loss to commence less than thirty (30) days after the date of accident, nor shall any policy which the insurer cancels or refuses to renew require that it be in force at the time the disability commences if the accident occurred while the policy was in force.

K) Specific dismemberment benefits shall not be in lieu of other benefits unless the specific dismemberment benefit equals or exceeds the other benefits.

L) Any accident only policy providing benefits which vary according to the type of accidental cause shall prominently set forth in the outline of coverage the circumstances under



which benefits payable are less than the maximum amount payable under the policy.

M) Nonrenewal of the policy shall be without prejudice to any continuous loss which commenced while the accident and sickness policy was in force, but the extension of benefits beyond the period the policy was in force may be predicated upon the continuous total disability of the covered person limited to a period of one year for health care benefits, limited to the duration of the policy benefit period (if any), and/or limited to the payment of the maximum benefits. The extension of benefits requirement does not apply to single premium nonrenewal policies.

N) Total Disability or Totally Disabled for the purposes of this Section means the complete incapacity of the covered person as the result of an injury or sickness:

i) to engage in any occupation for pay or profit, or if not employed, to engage in the normal activities of a person of the same age; and

ii) which requires the regular care of a physician other than a covered person.

O) Extension and limitation of coverage means if a covered person is totally disabled on his/her coverage termination date the coverage provided for that covered person by this policy and any attached riders will be extended. During the extended coverage the applicable policy and rider provisions, exclusions, exceptions and limitations will be the same as would have applied had coverage not terminated for such covered person. This extension is limited to confinement and/or expenses incurred:

i) for the injury or sickness which caused the total disability;

ii) during the uninterrupted continuance of the total disability; and

iii) during the twelve months following the covered person's coverage termination date.

P) All policies issued, whether or not such policy contains the refund provision, shall be administered to provide a refund of any unearned premiums upon death of any insured member from date of death if the Company receives a written request for unearned premium from the policy owner or the person entitled thereto.

2) Basic Hospital Expense Coverage

"Basic Hospital Expense Coverage" is a policy of accident and health insurance which provides coverage for a period of not less than thirty-one (31) days during any continuous hospital confinement for each person insured under the policy, for expense incurred for necessary treatment and services rendered as a result of accident or sickness. Coverage shall be for at least

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the following:

A) Daily hospital room and board in an amount not less than the lesser of:
   i) 80% of the charges for semi-private room accommodations; or
   ii) $100.00 per day; except that $100.00 may be reduced to $70.00 outside the metropolitan area.

B) Miscellaneous charges made by the hospital for services and supplies which are customarily rendered by the hospital and provided for use only during any one period of confinement in an amount not less than either 80% of the charges incurred up to at least $1,000.00 or ten times the daily hospital room and board benefits.; ~~and~~

C) Hospital outpatient services consisting of:
   i) hospital services on the day surgery is performed;
   ii) hospital services rendered within 72 hours after accidental injury, in an amount not less than $50.00; ~~and~~
   iii) X-ray and laboratory tests for the purpose of a diagnosis and treatment of an accidental injury or a sickness, in an amount not less than $100.00, but only to the extent that benefits for x-ray and laboratory tests would have been provided if rendered to an in-patient of the hospital.

D) Benefits provided under subsection (b)(2)(A) and (B) above, may be provided subject to a combined deductible amount not in excess of $100.00.

3) Basic Medical-Surgical Expense Coverage

"Basic Medical-Surgical Expense Coverage" is a policy of accident and health insurance which provides coverage for each person insured under the policy for the expenses incurred for the necessary services rendered by a physician for treatment of an injury or sickness. Coverage shall be for at least the following:

A) Surgical services:
   i) in amounts not less than those provided on a fee schedule based on the relative values contained in the state of New York certified surgical fee schedule, or the 1964 California Relative Value Schedule or other acceptable relative value scale of surgical procedures, up to a maximum of at least $500.00 for any one procedure; or
   ii) not less than 80% of the reasonable charges.

B) Anesthesia services, consisting of administration of necessary general anesthesia and related procedures in connection with covered surgical service rendered by a physician other than the physician (or his assistant) performing the surgical services:



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   i) in an amount not less than 80% of the reasonable charges; or
   ii) 15% of the surgical service benefit.

C) In-hospital medical services, consisting of physician services rendered to a person who is a bed patient in a hospital for treatment of sickness or injury, other than that for which surgical care is required, in an amount not less than 80% of the reasonable charges; or $5.00 per day for not less than twenty-one (21) days during one period of confinement.

4) Hospital Confinement Indemnity Coverage

"Hospital Confinement Indemnity Coverage" is a policy of accident and health insurance which provides for not less than $30.00 per day and for not less than thirty-one (31) days during any one period of confinement for each person insured under the policy. The policy may contain a benefit limit less than $30.00 per day if the policy benefit period is extended to reflect a maximum amount payable under a $30.00 per day policy with a thirty-one (31) day maximum confinement period for any one period of confinement.

5) Major Medical Expense Coverage

"Major Medical Expense Coverage" is an accident and health insurance policy which provides hospital, medical and surgical expense coverage, to an aggregate maximum of not less than $10,000.00; co-payment by the covered person not to exceed 25% of covered charges; a deductible stated on a per person, per family, per illness, per benefit period, or per year basis, or a combination of such bases not to exceed 5% of the aggregate maximum limit under the policy, unless the policy is written to complement underlying hospital and medical insurance in which case such deductible may be increased by the amount of the benefits provided by such underlying insurance, for each covered person. The aggregate maximum shall be increased not less than $3.00 for each $1.00 by which the deductible exceeds the minimum. Major medical expense insurance shall ~~must~~ provide for each covered person coverage of:

A) Daily hospital room and board expenses, prior to application of the co-payment percentage, for not less than $50.00 daily or, in lieu thereof, the average daily cost of semi-private room rate in the area where the insured resides, for a period of not less than thirty-one days during any period of continuous hospital confinement;

B) Miscellaneous Hospital Services, prior to application of the co-payment percentage, for an aggregate maximum of not less than $1,500.00 or 15 times the daily room and board rate if specified in dollar amount;

C) Surgical Services, prior to application of the co-payment percentage, to a maximum of not less than $600.00 for the

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most severe operation with the amounts provided for other operations reasonably related to such maximum amount; anesthetic services, prior to application of the co-payment percentage, of at least 15% of the covered surgical fees or, alternatively, if the surgical schedule is based on relative values, not less than the amount provided therein for anesthetic services at the same unit value as used for surgical schedule;

D) Physician visits, in or out of the hospital with minimum dollar amounts per visit, prior to application of the co-payment percentage, equal to not less than $8.00 per visit, covering not less than one visit per day and for an aggregate maximum of such covered charges of not less than $600.00;

E) Out of Hospital Diagnostic X-rays and Tests, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than $600.00;

F) Not fewer than 3 of the following additional benefits, prior to application of the co-payment percentage, for an aggregate maximum of such covered charges of not less than $1,000.00:~~,~~

i) private duty registered, or if not available, licensed practical nurse services performed by other than a family member while the insured is hospital confined;

ii) convalescent nursing home care;

iii) diagnosis and treatment by a radiologist or physiotherapist;

iv) rental of special medical equipment, as defined by the insurer in the policy;

v) artificial limbs or eyes, casts, splints, trusses or braces;

vi) treatment for functional nervous disorders, and mental or emotional disorders;

vii) out of hospital prescription drugs and medications.

6) Disability Income Protection Coverage

"Disability Income Protection Coverage~~,~~" is a policy which provides for periodic payments, weekly or monthly, for a specified period during the continuance of disability resulting from either sickness or injury or a combination thereof which has a maximum period of time for which it is payable during disability of at least six (6) months. A disability income protection policy may provide for reduction by the amount of Social Security benefits at inception of any claim but no benefit reduction shall be permitted to offset a Social Security benefit increase during a benefit period.

7) Accident Only Coverage

"Accident Only Coverage" is a policy of accident insurance which provides coverage, singly or in combination, for death,



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dismemberment, disability or hospital and medical care caused by accident. Accidental death and double dismemberment amounts under such a policy shall be at least $1,000.00 and a single dismemberment shall be at least $500.00.

8) Specified Coverages

"Specified Disease Coverage" pays benefits for the diagnosis and treatment of a specifically named disease or diseases. Any such policy shall ~~must~~ meet the following general requirements ~~rules~~ and one of the following sets of minimum standards for benefits~~, such~~. Insurance ~~insurance~~ covering cancer-, whether cancer only or in conjunction with other condition(s) or disease(s)-, shall ~~must~~ meet the standards of subsection (b)(8)(C) ~~(c)~~ or (D) ~~(d)~~ below. Insurance ~~insurance~~ covering specified disease(s) other than cancer shall ~~must~~ meet the standards of subsections (b)(8)(B) ~~(b)~~ or (D) ~~(d)~~. below.

A) General Requirements ~~Rules~~:

i) All advertising materials used in conjunction with a specified disease policy shall ~~must~~ accompany the policy filing.

ii) Policies covering a single specified disease or combination of specified diseases shall ~~may~~ not be sold or offered for sale other than as specified disease covered under this Section.

iii) Any policy issued pursuant to this Section which conditions payment upon pathological diagnosis of a covered disease~~,~~ shall also provide that if such a pathological diagnosis is medically inappropriate, a clinical diagnosis will be accepted in lieu thereof.

iv) Notwithstanding any other provision of this Part ~~regulation~~, specified disease policies shall provide benefits to any covered person not only for the specified disease(s), but also for any other condition(s) or disease(s) directly caused or aggravated by the specified disease(s) or the treatment of the specified disease(s).

v) Policies containing specified disease coverage shall be at least Guaranteed Renewable.

vi) No policy issued pursuant to this Section shall contain a waiting or probationary period greater than thirty (30) days.

vii) Payment may be conditioned upon a covered person receiving medically necessary care or treatment.

viii) Except for the uniform policy provision regarding other insurance with this insurer, benefits for specified disease coverage shall be paid regardless of other coverage available through individual health insurance.

ix) After the effective date of the coverage (or

applicable waiting period, if any) benefits shall begin with the first day of medical care or hospital confinement if such care or confinement is for a covered disease even though the diagnosis is made at some later date.

x) Skin cancer benefits within a cancer policy shall not be limited as it is a minimum standard of specified disease coverage and is a risk purported to be assumed. Skin cancer may only be excluded if it is in an additional benefit provision added to compliment underlying coverage not required by this Section.

B) The following minimum benefit standards apply to noncancer coverages: A policy which provides coverage for each person insured under the policy for a specifically named disease (or disease(s)) with a deductible amount not in excess of ($250.00) and an overall aggregate benefit limit, per person, of not less than ($10,000) and a benefit period of not less than two (2) years for at least the following incurred expenses:

i) Hospital room and board and any other hospital furnished medical services or supplies;

ii) Treatment by a legally qualified physician or surgeon;

iii) Private duty services of a registered nurse (R.N.);

iv) X-ray, radium, cobalt, nuclear medicine, and other therapeutic procedures used in diagnosis and treatment;

v) Professional ambulance for local service to or from a local hospital;

vi) Blood transfusions, including expense incurred for blood donors;

vii) Drugs and medicines prescribed by a physician;

viii) The rental of an iron lung or similar mechanical apparatus;

ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician;

x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; and

xi) May include coverage of any other expenses necessarily incurred for treatment of the disease.

C) A policy which provides coverage for each person insured under the policy for cancer-only coverage or in combination with one or more other specified diseases on an expense incurred basis for services, supplies, care and treatment that are prescribed by a physician as necessary for the treatment of cancer, in amounts not in excess of the usual and customary charges, with a deductible amount not in





excess of ~~($250.00)~~ and an overall aggregate benefit limit, per person, of not less than ~~($10,000)~~ and a 0benefit period of not less than two (2) years for at least the following:

i) Treatment by, or under the direction of, a legally qualified physician or surgeon;

ii) X-ray, radium, cobalt, chemotherapy, nuclear medicine, and other therapeutic procedures used in diagnosis and treatment;

iii) Hospital room and board and any other hospital furnished medical services or supplies;

iv) Blood transfusions and the administration thereof, including expense incurred for blood donors;

v) Drugs and medicines prescribed by a physician;

vi) Professional ambulance for local service to or from a local hospital;

vii) Private duty services of a registered nurse (R.N.) provided in a hospital; ~~and~~

viii) May include coverage of any other expenses necessarily incurred in the treatment of the disease; however, items (i), (ii), (iv), (v) and (vi) plus at least the following shall be included, but may be subject to copayment not to exceed ~~(20%)~~ of covered charges when rendered on an out-patient basis;

ix) Braces, crutches and wheel chairs as are deemed necessary by the attending physician for the treatment of the disease;

x) Emergency transportation if in the opinion of the attending physician it is necessary to transport the insured to another locality for treatment of the disease; ~~and~~

xi) Home Health Care, that is necessary care and treatment provided at the covered person's residence by a home health care agency or by others under arrangements made with a home health care agency. The program of treatment must be prescribed in writing by the covered person's attending physician, who must approve the program prior to its start. The physician must certify that hospital confinement would be otherwise required;~~.~~

xii) Physical, speech, hearing and occupational therapy;

xiii) Special equipment including hospital bed, toilette, pulleys, aspirator, incontinence pants, oxygen, surgical dressings, rubber shields, colostomy and ileostomy ~~eleostomy~~ appliances;

xiv) Reconstructive surgery when deemed necessary by the attending physician;

xv) Prosthetic devices; and

xvi) Nursing home care for non-custodial services.

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D) The following minimum benefit standards apply to specified disease coverages written on a per diem indemnity basis. Such coverages shall ~~must~~ offer covered persons:
   i) A fixed sum payment of at least $100 for each day ~~equal to one-half~~ of the hospital confinement for at least 365 days.
   ii) A fixed sum payment equal to one-half of the hospital in-patient benefit for each day of hospital or non-hospital out-patient surgery, chemotherapy and radiation therapy for at least 365 days of treatment.
   iii) Benefits tied to confinement in a skilled nursing home or to receipt of home health care are optional; if a policy offers these benefits, they must equal the following:
   A fixed sum payment equal to one-fourth the hospital in-patient benefit for each day of skilled nursing home confinement for at least 100 days~~,~~ (approximately $25.00 per day or $2,500 minimum benefit~~,~~). A fixed sum payment equal to one-fourth the hospital in-patient benefit for each day of home health care for at least 100 days ($2,500). Notwithstanding any other provision of this regulation, any restriction or limitation applied to the benefits in the above requirements, whether by definition or otherwise, shall be no more restrictive than those under Medicare.

E) "Specified Accident Coverage" is an accident insurance policy which provides coverage for a specifically identified kind of accident (or accidents) for each person insured under the policy for accidental death or dismemberment combined, with a benefit amount not less than $1,000 for double dismemberment and $500.00 for single dismemberment.

9) Limited Benefit Health Insurance Coverage
"Limited Benefit Health Insurance Coverage" is any policy or policies other than a policy or contract covering only a specified disease or diseases which provide benefits that are less than the minimum standards for benefits required under Section 2007.50(b)(2)- through (7) of this Part. Such policies or contracts may be delivered or issued for delivery in this State only if the outline of coverage required by Section 2007.80(k) of this Part is completed and delivered as required by Section 2007.80(b) of this Part.

10) Non-Conventional Coverage: Nothing contained in this subsection (b) ~~Section~~ shall prohibit the issuance of a policy that does not fall within subsection ~~paragraphs~~ (b)(1) through (9) above if such policy is experimental in nature and is appropriately and prominently described in the outline of coverage required by Section 2007.80(1) of this Part.



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11) The requirements of this Section do not apply to policies issued in compliance with Section 363 of the Illinois Insurance Code ~~Section 363~~ [215 ILCS 5/363] ~~(Ill. Rev. Stat. 1985, ch. 73, par. 975)~~.

(Source: Amended at 19 Ill. Reg. 16555, effective DEC 05 1995)

**Section 2007.80 Required Disclosure Provisions**

a) General Rules
   1) Each individual policy of accident and health insurance shall include a renewal, continuation, or nonrenewal provision. The language or specifications of such provision must be consistent with the type of policy to be issued. Such provision shall be appropriately captioned, shall appear on the first page of the policy, and shall clearly state the duration, where limited, of renewability and the duration of the term of coverage for which the policy is issued and for which it may be renewed.
   2) Except for riders or endorsements by which the insurer effectuates a request made in writing by the policyholder or exercises a specifically reserved right under the policy, all riders or endorsements added to a policy after date of issue or at reinstatement or renewal which reduce or eliminate benefits or coverage in the policy shall require signed acceptance by the policyholder. After date of policy issue, any rider or endorsement which increases benefits or coverage with a concomitant increase in premium during the policy term must be agreed to by the insured, except if the increased benefits or coverage is required by law.
   3) Where a separate additional premium is charged for benefits provided in connection with riders or endorsements, such premium charge shall be set forth in the policy.
   4) A policy which provides for the payment of benefits based on standards described as "usual and customary," "reasonable and customary," or words of similar import shall include a definition of such terms and an explanation of such terms in its accompanying outline of coverage.
   5) If a policy contains any limitations with respect to preexisting conditions, such limitations must appear as a separate paragraph of the policy and be labeled as "Preexisting Condition Limitations."
   6) All accident only policies shall contain a prominent statement on the first page of the policy or attached thereto in either contrasting color or in boldface type at least equal to the size of type used for policy captions, a prominent statement as follows:
   "This is an accident only policy and it does not pay

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benefits for loss from sickness."

7) All policies, except single premium nonrenewal policies, shall have a notice prominently printed on the first page of the policy or attached thereto stating in substance, that the policyholder shall have the right to return the policy within ten (10) days of its delivery and to have the premium refunded if after examination of the policy the policyholder is not satisfied for any reason.

8) If age is to be used as a determining factor for reducing the maximum aggregate benefits made available in the policy as originally issued, such fact must be prominently set forth in the outline of coverage.

9) If a policy contains a conversion privilege, it shall comply, in substance, with the following: the caption of the provision shall be "Conversion Privilege," or words of similar import. The provision shall indicate the persons eligible for conversion, the circumstances applicable to the conversion privilege, including any limitations on the conversion, and the person by whom the conversion privilege may be exercised. The provision shall specify the benefits to be provided on conversion or may state that the converted coverage will be as provided on a policy form then being used by the insurer for that purpose.

10) All specified disease policies shall contain a prominent statement on the first page of the policy in contrasting color and in bold face type at least equal to the size of type used for policy captions, a prominent statement as follows: "This is a limited policy. Read it carefully."

b) Outline of Coverage Requirements for Individual Coverages

1) No individual accident and health insurance policy shall be delivered or issued for delivery in this State unless an appropriate outline of coverage as prescribed in paragraphs (c) through - (l) below is completed as to such policy and is delivered in accordance with Section 355a(5)(a) of the Illinois Insurance Code [215 ILCS 5/355a(5)(a)] as enacted or thereafter amended.

2) In the event that a policy is issued on a basis other than that applied for, an outline of coverage properly describing the policy must accompany the policy when it is delivered and, if an outline of coverage was delivered earlier, contain the following statement, in not less than twelve (12) point type, immediately above the company name:

NOTICE

Read this outline of coverage carefully. It is not identical to the outline of coverage provided upon application and the coverage originally applied for has not been issued.

3) In those cases where a policy designed to supplement existing coverage is approved, the outline of coverage shall prominently



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state that coverage is designed to supplement other health insurance policies owned by the insured.

4) The appropriate outline of coverage for policies providing hospital coverage which only meets the standards of Section 2007.70(b)(2) of this Part shall be that statement contained in subsection (c) of this section. The appropriate outline of coverage for policies providing coverage which meets the standards of both Section 2007.70(b)(2) and (3) of this Part shall be the statement contained in paragraph (e) of this Section. The appropriate outline of coverage for policies providing coverage which meets the standards of Section 2007.70(b)(2) and (5) or Section 2007.70(b)(3) and (5) or Section 2007.70(b)(2), (3), and (5) of this Part shall be the statement contained in paragraph (g) of this Section.

c) Basic Hospital Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(2) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
BASIC HOSPITAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Basic Hospital Expense Coverage -- Policies of this category are designed to provide to persons insured coverage for hospital expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, and hospital outpatient services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for physicians or surgeons fees or unlimited hospital expenses.

3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy in the following order:

A) daily hospital room and board;
B) miscellaneous hospital services;
C) hospital out-patient services; and
D) other benefits, if any.)

(AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

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4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to charge premiums.)

d) Basic Medical-Surgical Expense Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(3) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)

BASIC MEDICAL-SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control your policy. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Basic Medical-Surgical Expense Coverage -- Policies of this category are designed to provide to persons insured coverage for medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for hospital expenses or unlimited medical surgical expenses.

3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

A) surgical services;

B) anesthesia services;

C) in-hospital medical services; and

D) other benefits, if any.)

(AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

e) Basic Hospital and Medical Surgical Expense Coverage (Outline of Coverage)



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An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(2) and (3) of this Part. The items included in the outline of coverage must appear in the sequence prescribed.

(COMPANY NAME)

BASIC HOSPITAL AND MEDIAL SURGICAL EXPENSE COVERAGE

OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Basic Hospital and Medical Surgical Expense Coverage -- Policies of this category are designed to provide, to persons insured, coverage for hospital and medical-surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, hospital out-patient services, surgical services, anesthesia services, and in-hospital medical services, subject to any limitations, deductibles and co-payment requirements set forth in the policy. Coverage is not provided for unlimited hospital or medical-surgical expenses.

3) (A brief specific description of the benefits, including dollar amounts and number of days duration where applicable, contained in this policy, in the following order:

A) daily hospital room and board;

B) miscellaneous hospital services;

C) hospital out-patient services;

D) surgical services;

E) anesthesia services;

F) in-hospital medical services; and

G) other benefits, if any.)

(AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)

4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

f) Hospital Confinement Indemnity Coverage (Outline of Coverage)

An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(4) of this Part. The items included in the outline of

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coverage must appear in the sequence prescribed:

(COMPANY NAME)
HOSPITAL CONFINEMENT INDEMNITY COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
2) Hospital Confinement Indemnity Coverage -- Policies of this category are designed to provide to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.
3) (A brief specific description of the benefits contained in this policy, in the following order:
   A) daily benefit payable during hospital confinement; and
   B) duration of benefit described in (A).)
   (AGENCY NOTE: The above description of benefits shall be stated clearly and concisely.)
4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)
5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)
6) (Any benefits provided in addition to the daily hospital benefit.)

g) Major Medical Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(5) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
MAJOR MEDICAL EXPENSE COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!



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2) Major Medical Expense Coverage -- Policies of this category are designed to provide, to persons insured, coverage for major hospital, medical, and surgical expenses incurred as a result of a covered accident or sickness. Coverage is provided for daily hospital room and board, miscellaneous hospital services, surgical services anesthesia services, in-hospital medical services, and out of hospital care, subject to any deductibles, co-payment provisions, or other limitations which may be set forth in the policy. Basic hospital or basic medical insurance coverage is not provided.
3) (A brief specific description of the benefits, including dollar amounts, contained in this policy, in the following order:
   A) daily hospital room and board;
   B) miscellaneous hospital services;
   C) surgical services;
   D) anesthesia services;
   E) in-hospital medical services;
   F) out of hospital care;
   G) maximum dollar amount for covered charges; and
   H) other benefits, if any.)
   (AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described.)
4) (A description of policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)
5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

h) Disability Income Protection Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(6) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
DISABILITY INCOME PROTECTION COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!
2) Disability Income Protection Coverage -- Policies of this category are designed to provide, to persons insured, coverage for disabilities resulting from a covered accident or sickness,

subject to any limitations set forth in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3) (A brief specific description of the benefits contained in this policy:)

(AGENCY NOTE: The above description of benefits shall be stated clearly and concisely.)

4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

i) Accident Only Coverage (Outline of Coverage)
An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70 (b)(7) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY)
ACCIDENT ONLY COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Accident Only Coverage -- Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident ONLY, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3) (A brief specific description of the benefits contained in this policy:)

(AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provision applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 2007.70(e) of this Part.)

4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)



j) Specified Disease or Specified Accident Coverage (Outline of Coverage)
An outline of coverage in the form prescribed below, shall be issued in connection with policies meeting the standards of Section 2007.70(b)(8) of this Part. The coverage shall be identified by the appropriate bracketed title. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
(SPECIFIED DISEASE) (SPECIFIED ACCIDENT) COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) (Specified Disease) (Specified Accident) Coverage -- Policies of this category are designed to provide, to persons insured, restricted coverage paying benefits ONLY when certain losses occur as a result of (specified diseases) or (specified accidents). Coverage is not provided for basic hospital, basic medical-surgical, or major medical expenses.

3) (A brief specific description of the benefits, including dollar amounts, contained in this policy:)

(AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with subsection (b)(1)(L) of Section 2007.70 of this Part.)

4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restriction or any reservation of right to change premiums.)

k) Limited Benefit Health Coverage (Outline of Coverage)
An outline of coverage, in the form prescribed below, shall be issued in connection with policies which do not meet the minimum standards of Sections 2007.70(b)(2-7) of this Part. The items included in the outline of coverage must appear in the sequence prescribed:

(COMPANY NAME)
LIMITED BENEFIT HEALTH COVERAGE
OUTLINE OF COVERAGE

1) Read Your Policy Carefully -- This outline of coverage provides a very brief description of the important features of your policy.

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This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

2) Limited Benefit Health Coverage -- Policies of this category are designed to provide, to persons insured, limited or supplemental coverage.

3) (A brief specific description of the benefits, including dollar amounts, contained in this policy:)

(AGENCY NOTE: The above description of benefits shall be stated clearly and concisely, and shall include a description of any deductible or co-payment provisions applicable to the benefits described. Proper disclosure of benefits which vary according to accidental cause shall be made in accordance with Section 2007.70(b)(1)(l) of this Part.)

4) (A description of any policy provisions which exclude, eliminate, restrict, reduce, limit, delay, or in any other manner operate to qualify payment of the benefits described in (3) above.)

5) (A description of policy provisions respecting renewability or continuation of coverage, including age restrictions or any reservation of right to change premiums.)

1) Non-Conventional Coverage (Outline of Coverage)

The outline of coverage shall include the following information:

1) The name and principal address of the insurer.

2) An appropriate statement of identification of the type of coverage provided by the policy.

3) A description of each of the principal benefits and coverages, including the benefit amounts, duration or limits, elimination periods, inner limits and any other items appropriate to the coverage provided.

4) A description of the terms and conditions of renewability of the policy, including any limitations by age, time or event, rights to change premium, status requirements and any other matters appropriate to the terms and conditions of renewability (including any rights of cancellation reserved to the insurer).

5) A description of the principal exceptions, reductions and limitations contained in the policy, including the preexisting conditions, if any, and the circumstances under which any reduction provisions become operative.

6) A statement that the Outline of Coverage is only a brief summary of the policy and is not the contract of insurance. The policy itself sets forth the rights and obligations of the insured and insurer.

(Source: Amended at 19 Ill. Reg. 16555, effective DEC 05 1995)



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**Section 2007.90 Requirements for Replacement**

a) Application forms shall include a question designed to elicit information as to whether the insurance to be issued is intended to replace any other accident and health insurance presently in force. A supplementary application or other form to be signed by the applicant containing such a question may be used.

b) Upon determining that a sale will involve replacement, an insurer, other than a direct response insurer, or its agent shall furnish the applicant, prior to issuance or delivery of the policy, the notice described in subsection (d) below. One (1) copy of such notice shall be retained by the applicant and an additional copy signed by the applicant shall be retained by the insurer. A direct response insurer shall deliver to the applicant upon issuance of the policy, the notice described in subsection (e) below.

c) In no event, however, will such a notice be required in the solicitation of the following types of policies: accident only and single premium nonrenewable policies.

d) The notice required by subsection (b) above for an insurer, other than a direct response insurer, shall provide, in substantially the following form:

NOTICE TO APPLICANT REGARDING REPLACEMENT
OF ACCIDENT AND HEALTH INSURANCE

According to (your application) (information you have furnished), you intend to lapse or otherwise terminate existing accident and health insurance and replace it with a policy to be issued by (Company Name) Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1) Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

3) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history.

Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain

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that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on:

_____
Date

_____
Applicant's Signature

e) The notice required by subsection (b) above for a direct response insurer shall be as follows:
According to (your application) (information you have furnished) you intend to lapse or otherwise terminate existing accident and health insurance and replace it with the policy delivered herewith issued by (Company Name) Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.
1) Health conditions which you may presently have, (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
3) (To be included only if the application is attached to the policy.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, read the copy of the application attached to your new policy and be sure that all questions are answered fully and correctly. Omissions or misstatements in the application could cause an otherwise valid claim to be denied. Carefully check the application and write to (Company Name and Address) within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

_____
Company Name

(Source: Amended at 19 Ill. Reg. 16555, effective DEC 05 1995)



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1) Heading of the Part: Radiation Safety Requirements For Industrial Radiographic Operations

2) Code Citation: 32 Ill. Adm. Code 350

3)

| Section Number: | Adopted Action: |
|---|---|
| 350.30 | Amendment |
| 350.1000 | Amendment |
| 350.3045 | Amendment |
| 350.4010 | Amendment |
| 350.4020 | Amendment |

4) Statutory Authority: Implementing and authorized by the Radiation Protection Act of 1990 [420 ILCS 40].

5) Effective Date of Amendments: November 27, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Do these amendments contain incorporations by reference? Yes, the amendment contains material incorporated by reference pursuant to Section 100/5-75(a) of the Administrative Procedure Act [5 ILCS 100/5-75(a)].

8) Date filed in Agency's Principal Office: November 22, 1995

9) Notice of Proposal Published in the Illinois Register: July 28, 1995 (19 Ill. Reg. 10966)

10) Has JCAR issued a Statement of Objections to these Amendments? No

11) Differences between proposal and final version:

a) In Section 350.3045(e), by changing the word "their" to the phrase "his or her".

b) In Section 350.3045(f), by changing the word "their" to the phrase "his or her".

c) In Section 350.4020(c)(6), by striking through the word "requirement" and inserting and underlining the word "required".

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these amendments replace an emergency amendment currently in effect? No

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14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Amendments: This amendment will: (1) in Section 350.30, update a cross-reference in the definition of "Storage container"; (2) in Section 350.1000(a)(1), permit the use of an alternate value of torque for the performance testing criteria (this change will satisfy an NRC compatibility issue); (3) clarify the language in Section 350.3045, by deleting subsection (d)(5) and inserting a new subsection (e) to clarify that an alarm ratemeter shall be used by each worker at a location other than a permanent installation; (4) require radiographers and radiographer trainees to carry their certification cards while performing radiography; (5) in Section 350.4010, clarify the licensing and registration requirements for industrial radiographic operations; and (6) in Section 350.4020(b), add a new subsection (4) which will relieve registrants of the requirement that the Radiation Safety Officer shall also maintain a certification as an industrial radiographer.

16) Information and questions regarding these amendments shall be directed to:

Robert B. Holtsclaw
Staff Attorney
Department of Nuclear Safety
1035 Outer Park Drive
Springfield, Illinois 62704
(217) 524-1003 (voice)
(217) 782-6133 (TDD)

The full text of the Adopted Amendments begin on the next page:



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TITLE 32: ENERGY
CHAPTER II: DEPARTMENT OF NUCLEAR SAFETY
SUBCHAPTER b: RADIATION PROTECTION

PART 350
RADIATION SAFETY REQUIREMENTS FOR INDUSTRIAL RADIOGRAPHIC OPERATIONS

SUBPART A: GENERAL PROVISIONS

Section
350.10 Purpose
350.20 Scope
350.25 Incorporations by Reference
350.30 Definitions
350.40 Exemptions
350.50 Receipt, Transfer and Disposal of Sources of Radiation

SUBPART B: EQUIPMENT CONTROL

Section
350.1000 Requirements for Radiography Equipment Using Radiographic Exposure Devices
350.1005 Requirements for Radiography Equipment Using Radiation Machines
350.1010 Limits on Levels of Radiation for Radiographic Exposure Devices, Source Changers and Transport Containers
350.1020 Locking of Sources of Radiation
350.1030 Permanent Storage Precautions
350.1040 Radiation Survey Instruments
350.1050 Testing for Leakage or Contamination, Repair, Tagging, Opening, Modification and Replacement of Sealed Sources
350.1060 Quarterly Inventory
350.1070 Utilization Logs
350.1080 Inspection and Maintenance
350.1090 Permanent Radiographic Installations

SUBPART C: PERSONAL RADIATION SAFETY REQUIREMENTS FOR RADIOGRAPHERS AND RADIOGRAPHER TRAINEES

Section
350.2010 Training and Testing
350.2020 Operating and Emergency Procedures
350.2030 Personnel Monitoring Control
350.2040 Supervision of Radiographer Trainees

SUBPART D: PRECAUTIONARY PROCEDURES IN RADIOGRAPHIC OPERATIONS

Section
350.3010 Access Control and Security

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AUTHORITY: Implementing and authorized by the Radiation Protection Act of 1990 [420 ILCS 40].

SOURCE: Filed and effective April 20, 1974, by the Department of Public Health; transferred to the Department of Nuclear Safety by P.A. 81-1516, effective December 3, 1980; codified at 7 Ill. Reg. 14744; recodified at 10 Ill. Reg. 11265; amended at 10 Ill. Reg. 17287, effective September 25, 1986; amended at 13 Ill. Reg. 13592, effective August 11, 1989; amended at 18 Ill. Reg. 7263, effective May 2, 1994; expedited correction at 18 Ill. Reg. 10943, effective May 2, 1994; amended at 19 Ill. Reg. 8250, effective June 12, 1995; amended at 19 Ill. Reg. 16591, effective NOV 27 1995.

SUBPART A: GENERAL PROVISIONS

**Section 350.30 Definitions**

As used in this Part, the following definitions apply:

"ALARA" means as low as is reasonably achievable as defined in 32 Ill. Adm. Code 310.20.

"Associated equipment" means equipment used in conjunction with a



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radiographic exposure device to make radiographic exposure where such equipment drives, guides, or comes into contact with the source (i.e., guide tube, control tube, crank, removable source stop, "J" tube).

"Cabinet radiography" means industrial radiography conducted in an enclosure or cabinet so shielded that doses to individual members of the public at every location on the exterior meet the limitations specified in 32 Ill. Adm. Code 340. 310(a).

"Cabinet x-ray system" means an x-ray system with the x-ray tube installed in an enclosure which, independent of existing architectural structures except the floor on which it may be placed, is intended to contain at least that portion of a material being irradiated, provide radiation attenuation and exclude personnel from its interior during generation of x radiation. Included are all x-ray systems designed primarily for the inspection of carry-on baggage at airline, railroad and bus terminals and in similar facilities. An x-ray tube used within a shielded part of a building or x-ray equipment which may temporarily or occasionally incorporate portable shielding is not considered a cabinet x-ray system.

"Collimator" means a radiation shield of lead or other heavy metal which is placed on the end of a guide tube or directly onto a radiographic exposure device to restrict the size and shape of the radiation beam when the sealed source is moved into position to make a radiographic exposure.

"Crank-out device" means the cable, protective sheath and handcrank used to move the sealed source from the shielded to the unshielded position to make an industrial radiographic exposure.

"Enclosed radiography" means industrial radiography conducted in an enclosed cabinet or room and includes cabinet radiography and shielded-room radiography.

"GED" means general equivalency diploma.

"Industrial radiography" means the process used to perform the examination of the macroscopic structure of materials by non-destructive methods using radioactive material or radiation machines.

"Lay-barge radiography" means industrial radiography performed on any water vessel used for laying pipe.

"Lixiscope" means a portable light-intensified imaging device using a sealed source.

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"Lock-out survey" means a radiation survey performed to determine that a sealed source is in its shielded position. The lock-out survey is performed before moving the radiographic exposure device or source changer to a new location. The lock-out survey is also performed when securing the radiographic exposure device or source changer against unauthorized removal.

"Permanent radiographic installation" means an installation or structure designed or intended for radiography and in which radiography is regularly performed.

"Permanent use or storage location" means a location listed on a radioactive material license or a certificate of registration where sources of radiation are used or stored.

"Personal supervision" means the provision of guidance and instruction to a radiographer trainee by a radiographer who is:

physically present at the site;

in visual contact with the radiographer trainee while the trainee is using sources of radiation; and

in such proximity that immediate assistance can be given if required.

"Radiation safety officer" means an individual who is both designated as a radiation safety officer in accordance with Section 350.4020 and who meets the requirements of Section 350.4020 and 32 Ill. Adm. Code 310.20.

"Radiographer" means any individual who performs or personally supervises industrial radiographic operations. Radiographers shall meet the requirements of Section 350.2010(a) and shall comply with the requirements of 32 Ill. Adm. Code: Chapter II, Subchapters b and d, all license conditions, if any, and orders of the Department.

"Radiographer trainee" means any individual who uses sources of radiation and related handling tool or radiation survey instruments under the personal supervision of a radiographer. Radiographer trainees shall meet the requirements of Section 350.2010(b) and shall comply with the requirements of 32 Ill. Adm. Code: Chapter II, Subchapters b and d, all license conditions, if any, and orders of the Department.

"Radiographic exposure device" means any instrument containing a sealed source fastened or contained therein, in which the sealed source or shielding thereof may be moved or otherwise changed from a



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shielded to an unshielded position for purposes of making a radiographic exposure (i.e, camera).

"Sealed source" (i.e., pill) means any capsule or matrix as defined in 32 Ill. Adm. Code 310.20.

"Shielded position" means the location within the radiographic exposure device or storage container which, by manufacturer's design, is the proper location for storage of the sealed source.

"Shielded-room radiography" means industrial radiography conducted in a room so shielded that doses to individual members of the public at every location on the exterior meet the limitations as specified in 32 Ill. Adm. Code 340.310(a) (i.e., bay, bunker, cell).

"Source assembly" means a component to which the sealed source is affixed or in which the sealed source is contained. The source assembly includes the sealed source (i.e., pigtail).

"Source changer" means a device designed and used for replacement of sealed sources in radiographic exposure devices, including those source changers also used for transporting and storage of sealed sources.

"Storage container" means the structure in which sealed sources are secured and stored at a permanent storage location as described in Section 350.4010(c)(5) ~~350.4010(d)(1)~~.

"Temporary job site" means any location that is not specifically listed on a radioactive material license or certificate of registration where industrial radiography is performed for 180 days or less during any consecutive 12 months.

"Transport container" means a package that is designed and constructed to provide radiation safety and security when sealed sources are transported and meets all applicable regulations of the U.S. Department of Transportation.

"Underwater radiography" means industrial radiography performed when the radiographic exposure device and related equipment are beneath the surface of water.

(Source: Amended at 19 Ill. Reg. 16591, effective NOV 27 1995)

SUBPART B: EQUIPMENT CONTROL

**Section 350.1000 Requirements for Radiography Equipment Using Radiographic**

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**Exposure Devices**

a) Equipment used in industrial radiographic operations involving the use of radiographic exposure devices shall meet the following minimum criteria:
   1) Each radiographic exposure device and all associated equipment shall meet the requirements specified in American National Standards Institute (ANSI) N432-1980, "Radiological Safety for the Design and Construction of Apparatus for Gamma Radiography," published January 1981, as NBS Handbook 136, exclusive of subsequent amendments or editions. However, equipment used in industrial radiographic operations need not comply with section 8.9.2(c) of the Endurance Test in ANSI N432-1980, if the prototype equipment has been tested using a torque value representative of the torque that an individual using the radiography equipment can realistically exert on the lever or crankshaft of the drive mechanism.
   2) Each radiographic exposure device shall have attached to it one or more durable, legible, clearly visible labels bearing the:
      A) Chemical symbol and mass number of the radionuclide in the device;
      B) Activity of the sealed source and the date on which this activity was last measured;
      C) Model and serial number of the sealed source;
      D) Manufacturer of the sealed source; and
      E) Licensee's name, address and telephone number.
   3) Each radiographic exposure device intended for use as a Type B transport container shall meet the applicable requirements of 32 Ill. Adm. Code 341.
   4) Radiographic exposure devices and associated equipment that allow the source to be moved out of the device for routine operation shall meet the following additional requirements:
      A) The coupling between the source assembly and the control cable shall be designed in such a manner that the source assembly will not become disconnected if cranked outside the guide tube. The coupling shall be such that it cannot be unintentionally disconnected under normal conditions.
      B) The device shall automatically secure the source assembly when it is cranked back into the shielded position within the device. This securing system shall only be released by means of a deliberate operation of the exposure device.
      C) The outlet fittings, lock box and drive cable fittings on each radiographic exposure device shall be equipped with safety plugs or covers, which shall be installed during storage and transportation, to protect the source assembly from water, mud, sand or other foreign matter.
      D) Each sealed source or source assembly shall have attached to it, or engraved in it, a durable, legible, visible label



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with the words: "DANGER-RADIOACTIVE." The label shall not interfere with the safe operation of the exposure device or associated equipment.
      E) The guide tube shall have passed a kinking test that closely approximates the kinking forces likely to be encountered during use and the crushing tests for the control units specified in ANSI ~~American--National--Standards--Institute (ANSI)~~ N432-1980, "Radiological Safety for the Design and Construction of Apparatus for Gamma Radiography," published January 1981, as NBS Handbook 136, exclusive of subsequent amendments or editions.
      F) Use of a guide tube shall be necessary to move the source out of the device.
      G) An exposure head, endcap or similar device designed to prevent the source assembly from extending beyond the end of the guide tube shall be attached to the outermost end of the guide tube during radiographic operations.
      H) The guide tube exposure head connection shall be able to withstand the tensile test for control units specified in ANSI N432-1980, "Radiological Safety for the Design and Construction of Apparatus for Gamma Radiography," published January 1981, as NBS Handbook 136, exclusive of subsequent amendments or editions.
      I) Source changers shall provide a system for assuring that the source will not be accidentally withdrawn from the changer when connecting or disconnecting the drive cable to or from a source assembly.

b) Modification of any radiographic exposure device and associated equipment is prohibited unless the Department, the U.S. Nuclear Regulatory Commission or an Agreement State has determined that the design of any replacement component, including source holder, source assembly, control or guide tube would not compromise the design safety features of the system.

c) All radiographic exposure devices and associated equipment manufactured after July 1, 1994, and acquired by licensees shall comply with the requirements of this Section.

d) All radiographic exposure devices and associated equipment in use after January 10, 1996, shall comply with the requirements of this Section.

e) Each radiographic exposure device, source changer and storage container shall be provided with a lock or lockable outer container designed to prevent unauthorized or accidental removal or exposure of a serial source.

f) Each radiographic exposure device and each transport container shall bear a permanent, durable, legible, clearly visible marking or label(s) which has, as a minimum, the standard radiation caution symbol, depicted in 32 Ill. Adm. Code 340.Illustration A, and the following wording:

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CAUTION (OR DANGER)
RADIOACTIVE MATERIAL--DO NOT HANDLE
NOTIFY CIVIL AUTHORITIES (OR NAME OF COMPANY)

In addition, transport containers shall meet the applicable requirements of 32 Ill. Adm. Code 341.

(Source: Amended at 19 Ill. Reg. 16591, effective NOV 27 1995)

SUBPART D: PRECAUTIONARY PROCEDURES IN RADIOGRAPHIC OPERATIONS

**Section 350.3045 Operating Requirements**

a) When radiography is performed at a location other than a permanent radiographic installation, a minimum of two radiographic personnel shall be present to operate the radiographic exposure device. At least one of the radiographic personnel shall be a radiographer. The other radiographic personnel may be either a radiographer or radiographer trainee.

b) Collimators shall be used in industrial radiographic systems that use crank-out devices except when physically impossible.

c) Other than a radiographer, or a radiographer trainee who is under the personal supervision of a radiographer, no person shall manipulate controls or operate equipment used in industrial radiographic operations.

d) At each job site, the following shall be supplied by the licensee or registrant:
   1) The appropriate barrier ropes and signs;
   2) At least one operable, calibrated survey instrument;
   3) A current whole body individual monitoring device (TLD or film badge) for each worker; and
   4) An operable, calibrated pocket ionization chamber (i.e., pocket dosimeter) with a range of zero to 51.6 micro C/kg (200 mR) for each worker.~~;--and~~
   ~~5) An operable, calibrated, alarm ratemeter--for--each---worker--who performs industrial radiography with a sealed source.~~

e) Each worker who performs industrial radiography with a sealed source at a location other than a permanent radiography installation shall have on his or her person an operable, calibrated alarm ratemeter.

f) Each radiographer or radiographer trainee at a job site shall have on his or her person a valid industrial radiographer certification card issued by the Department pursuant to the provisions of 32 Ill. Adm. Code 405.

g)~~e)~~ Industrial radiographic operations shall not be performed if any of the items in subsections (d), (e) and (f) ~~subsection (d)~~ above are unavailable ~~not available~~ at the job site or are inoperable.



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(Source: Amended at 19 Ill. Reg. 16591, effective NOV 27 1995)

**Section 350.4010 Licensing and Registration Requirements for Industrial Radiographic Operations**

a) Radioactive material used in industrial radiographic operations shall be licensed in accordance with 32 Ill. Adm. Code 330.

b) Radiation machines used in industrial radiographic operations shall be registered in accordance with 32 Ill. Adm. Code 320.
AGENCY NOTE: If a licensee does not use radiation machines and uses only radioactive materials, then the licensed activities do not need to be registered in accordance with the requirements of 32 Ill. Adm. Code 320.

c) In addition to the licensing requirements in 32 Ill. Adm. Code 330 ~~and the registration requirements in 32 Ill. Adm. Code 320~~, an application for a license ~~or--certificate--of--registration~~ shall include the following information:
   1) A schedule or description of the program for training radiographic personnel that specifies:
      A) Initial training;
      B) Periodic training;
      C) On-the-job training; and
      D) Methods to be used by the licensee or registrant to determine the knowledge, understanding and ability of radiographic personnel to comply with Department rules, licensing or registration requirements, and the operating and emergency procedures of the applicant;
   2) Written operating and emergency procedures, including all items listed in Section 350.2020;
   3) A description of the internal inspection system or other management control to ensure that radiographic personnel comply with license conditions, regulations and orders of the Department and the applicant's operating and emergency procedures; ~~and~~
   4) A description of the organization of the industrial radiographic program, including delegation of authority and responsibility for operation of the radiation safety program~~;~~.

~~d) An application for a radioactive material license shall also include:~~
   5)~~1)~~ A list of proposed permanent radiographic installations and descriptions of proposed permanent storage and use locations. Radioactive material shall not be stored at a permanent storage location or used at a permanent use location unless such storage or use location is specifically authorized by the license. A storage or use location is permanent if radioactive material is stored or used at the location for more than 180 days during any consecutive 12 months~~;~~.
   6)~~2)~~ A description of the program for inspection and maintenance of

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radiographic exposure devices, transport containers and storage containers (including applicable items in Sections 350.1080 and 350.Appendix B);~~.~~

7)~~3)~~ For applicants seeking ~~If---a--license--application--seeks~~ authorization to perform underwater radiography, a description of:

A) Radiation safety procedures and radiographer responsibilities unique to the performance of underwater radiography;

B) Radiographic equipment and radiation safety equipment unique to underwater radiography; and

C) Methods for watertight encapsulation of equipment; and~~.~~

8)~~4)~~ For applicants seeking ~~If---a---license---application---seeks~~ authorization to perform lay-barge radiography, a description of:

A) Transport procedures for radioactive material to be used in industrial radiographic operations;

B) Storage facilities for radioactive material; and

C) Methods for restricting access to radiation areas.

(Source: Amended at 19 Ill. Reg. 16591, effective NOV 27 1995)

**Section 350.4020 Radiation Safety Officer**

a) Each licensee or registrant performing industrial radiography shall designate a Radiation Safety Officer (RSO).
AGENCY NOTE: The Department will list the name of the RSO on each radioactive material license.

b) The RSO's qualifications shall include, but not be limited to:

1) Possession of a high school diploma or a certificate of high school equivalency based on the GED test;

2) Completion of the training and testing requirements of Section 350.2010(a)(2), (3) and (4); **and**

3) 2 years of documented experience related to radiation protection, including knowledge of industrial radiographic operations; and~~.~~

4) For licensees only, the RSO shall also maintain certification as an industrial radiographer as specified in Section 350.2010(a)(1).

c) The specific duties of the RSO shall include, but need not be limited to, the following:

1) Establish and oversee operating, emergency and ALARA procedures, and review them at least annually to ensure that the procedures are current and conform with 32 Ill. Adm. Code: Chapter II, Subchapters b and d;

2) Oversee the radiation protection training program for radiographic personnel;

3) Ensure that required radiation surveys and leak tests are performed and documented in accordance with 32 Ill Adm. Code: Chapter II, Subchapter b and d;



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4) Ensure that corrective measures are taken when levels of radiation exceed established limits;

5) Ensure that individual monitoring devices are calibrated and used properly by industrial radiographic personnel, that records are kept of the monitoring results and that timely notifications are made as required by this Part and 32 Ill. Adm. Code 400;

6) Ensure that required ~~requirement~~ interlock switches and warning signals are functioning and that radiation signs, ropes and barriers are properly posted and positioned;

7) Investigate and report to the Department each known or suspected case of excessive radiation exposure to an individual or radiation level detected in excess of limits established by 32 Ill. Adm. Code: Chapter II, Subchapters b and d and each theft or loss of source(s) of radiation, determine the cause and take steps to prevent recurrence;

8) Assume control and have the authority to institute corrective actions in emergency situations or unsafe conditions;

9) Maintain records as required by 32 Ill. Adm. Code: Chapter II, Subchapters b and d (see Section 350.Appendix C);

10) Ensure proper storage, labeling, transport and use of exposure devices and sources of radiation;

11) Ensure that quarterly inventory and inspection and maintenance programs are performed in accordance with Section 350.1060 and 350.1080; and

12) Ensure that personnel comply with 32 Ill. Adm. Code: Chapter II, Subchapter b and d, the conditions of the license and the operating and emergency procedures of the licensee or registrant.

d) The licensee or registrant shall ensure that the duties in subsection (c) above are executed.

(Source: Amended at 19 Ill. Reg. 16591, effective NOV 27 1995)

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1) Heading of the Part: Real Estate Appraiser Certification

2) Code Citation: 68 Ill. Adm. Code 1455

3) Section Numbers: Adopted Action:

| | |
|---|---|
| 1455.70 | Amendment |
| 1455.200 | Amendment |
| 1455.210 | Repealed |
| 1455.300 | Amendment |
| 1455.305 | New Section |

4) Statutory Authority: Implementing Article 2 of the Real Estate License Act of 1983 [223 ILCS 455/Art. 2] and authorized by Section 60(7) of the Civil Administrative Code of Illinois [20 ILCS 2105/60(7)]

5) Effective Date of Rulemaking: December 1, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: August 16, 1995

9) Notice of Proposal Published in Illinois Register: September 1, 1995, 19 Ill. Reg. 12431

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version: Technical and formatting changes recommended by JCAR were incorporated in the final version.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? All the changes agreed upon by the Agency and JCAR have been made.

13) Will this rulemaking replace an emergency rule currently in effect? Yes

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking: The proposed rulemaking sets forth the regulatory fee structure for appraiser licensees under the Illinois Real Estate License Act of 1983. P.A. 89-23, effective July 1, 1995, repealed statutory fees applying to appraisers which were specified in the Act and provided instead that fees would be set by rule by the Commissioner. The proposed rules implement that statutory change.

16) Information and questions regarding these adopted amendments shall be



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directed to:

John Arthur
Office of the Commissioner of Savings and Residential Finance
500 East Monroe, Suite 800
Springfield, Illinois 62701-1509
Telephone: 217/782-6181

The full text of the Adopted Amendment begins on the next page:

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TITLE 68: PROFESSIONS AND OCCUPATIONS
CHAPTER VII: DEPARTMENT OF PROFESSIONAL REGULATION
SUBCHAPTER b: PROFESSIONS AND OCCUPATIONS

PART 1455
REAL ESTATE APPRAISER CERTIFICATION

SUBPART A: RESIDENTIAL AND GENERAL CERTIFICATION



SUBPART B: EDUCATION PROVIDERS



SUBPART C: GENERAL



AUTHORITY: Implementing Article 2 of the Real Estate License Act of 1983 [225 ILCS 455/Art. 2] and authorized by Section 60(7) of the Civil Administrative Code of Illinois [20 ILCS 2105/60(7)].

SOURCE: Emergency rules adopted at 16 Ill. Reg. 16196, effective September 30, 1992, for a maximum of 150 days; rules adopted at 17 Ill. Reg. 1589, effective January 26, 1993; emergency amendment at 17 Ill. Reg. 6668, effective April 19, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 13494, effective July 30, 1993; amended at 18 Ill. Reg. 2379, effective January 28, 1994; emergency amendment at 18 Ill. Reg. 3006, effective February 10, 1994,



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for a maximum of 150 days; amended at 18 Ill. Reg. 8428, effective May 24, 1994; amended at 19 Ill. Reg. 9176, effective June 26, 1995; emergency amendment at 19 Ill. Reg. 12503, effective August 16, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16604, effective DEC 01 1995.

SUBPART A: RESIDENTIAL AND GENERAL CERTIFICATION

**Section 1455.70 Nonresident/Temporary Practice**

a) A nonresident appraiser, licensed/certified in another jurisdiction, may apply for a temporary appraisal practice permit by filing with the Department, on an application provided by the Department. The information submitted on the application shall include, but not be limited to, the following:
   1) The applicant's name, address, social security number, any other such information as might be necessary to identify the applicant.
   2) A certification from the agency in the applicant's home state of licensure/certification, certifying that the applicant is a duly licensed/certified real estate appraiser in good standing; and, setting forth any discipline taken (or pending) by the agency against the applicant.
   3) An estimate of the amount of time required to perform the appraisal assignments(s) and a description of the property or properties to be appraised by the applicant.
   4) An irrevocable consent that service of process in any action against the applicant that may arise from the applicant's Illinois appraisal activities may be made by delivery of process on the Illinois Appraisal Administrator.
   5) Such other information as may be necessary to determine the applicant's eligibility for temporary appraisal privileges within the State of Illinois.

b) Limitations and requirements for temporary appraisal practice are as follows:
   1) The temporary practice permit shall be for a period of 60 days from the date of issuance. The permit may not be renewed but may be extended for 30 days upon written request and payment of an extension fee, at least 14 business days prior to the expiration of the original temporary practice permit;
   2) Each applicant is limited to 2 temporary appraisal practice permits in any calendar year;
   ~~3) The fee for each temporary permit shall be $80.00, shall accompany the application and is non-refundable. The fee for extension of an appraisal permit is $80.00, shall accompany the written request for extension and is not refundable;~~
   34) Persons granted temporary appraisal practice permits shall not advertise, solicit or otherwise represent themselves as State Licensed Real Estate Appraisers, Certified Residential Real

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Estate Appraisers or Certified General Real Estate Appraisers; and

45) Applicants will be required to pay any fee required by the federal government under Title XI of the Federal Institutions Reform, Recovery and Enforcement Act of 1989.

(Source: Amended at 19 Ill. Reg. 16604, effective DEC 01 1995)

SUBPART B: EDUCATION PROVIDERS

**Section 1455.200 Approval of Education Providers/Courses**

a) An entity seeking approval as an appraisal education provider shall submit an application, on forms provided by the Department, and shall meet the following minimum criteria:
   1) The provider shall:
      A) Maintain a fixed office that is adequate for the maintenance of all records, office equipment, files, telephone equipment and office space necessary for customer service;
      B) Offer a minimum of one curriculum that conforms to the standards of subsections (c) and (d) of this Section;
      C) Administer a mandatory final examination for each pre-license course offering;
      D) Provide each student within 21 days of completion of each course (or within 21 days of a request by a student or the Department), a certification of completion, transcript or other document verifying hours of attendance, successful course completion and identifying the course by name and number, if any. In addition, such certificate, transcript or other document shall indicate the provider's address and telephone number, the location and date of the course, and include an authorized signature of the course provider's representative. Documentation for CE courses may be in the form of a Uniform Request for Continuing Education, which is a form supplied by national appraisal organizations;
      E) Submit the fee(s) set forth in Section 1455.305 ~~1455.210~~;
      F) Comply with all applicable fire, building, zoning, health, safety and accessibility codes and standards pertaining to the premises, equipment and facilities of the course site;
      G) Provide the student with information which specifies the course of study to be offered; the tuition to be charged; the school's policy regarding refund of unearned tuition when a student is dismissed or withdraws voluntarily or through hardship; any additional fee to be charged for supplies, materials or books which become the property of the student upon payment; and such other matters as are material to the relationship between the school and the student (e.g., cost of retaking a course, current status of licensure, any disciplinary action taken by the Department and attendance requirements);
      H) Maintain for each student a record which shall include the course of instruction undertaken, dates of attendance, and areas of study completed satisfactorily. Each student's record shall be maintained by the school for a period of at least 7 years and shall be available for inspection by the student or by the Department or its designee during regular business hours; and
      I) Employ competent instructors.
         i) Beginning December 31, 1993, instructors for courses in the IL IV and IL V curricula shall be Certified General Real Estate Appraisers or full time faculty members of a 4-year college or university.
         ii) Beginning December 31, 1993, instructors for courses in the IL I, IL II and IL III curricula shall be Certified Residential or Certified General Real Estate Appraisers or full time faculty members of a 4-year college or university.
         iii) For CE courses and courses in the IL E curriculum, instructors should be Certified Residential or General Real Estate Appraisers or persons with education and/or experience in appraisal or the subject matter of the course.
   2) Approved course providers shall not advertise as being endorsed, recommended or accredited by the Department. Course providers may indicate that the provider and course of study have been approved by the Department.
   3) Illinois Colleges, Universities, and Agencies
      A) Colleges and universities which apply as appraisal education providers under subsection (a)(1) above shall be accredited by the regional accrediting body and offer either or both an associate's and baccalaureate degree program.
      B) Illinois Colleges and universities will not be required to pay the application fees required by Section 1455.305 ~~1455.210~~.
      C) Agencies under the jurisdiction of the Governor of the State of Illinois will not be required to pay the application fees required for education providers by Section 1455.305.
b) Appraisal Education Sub-Providers
   1) Sub-organizations (such as chapters, branch schools and local associations) may seek CE course approval (licensure) under the appraisal education provider's license of the parent organization. Such sub-providers may not seek approval for pre-license appraisal courses. Sub-providers may offer pre-license courses as a co-sponsor with the parent provider.
   2) Sub-organizations need not apply to the Department to become an



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approved CE course provider but may seek course approval under the providership of the parent organization.

A) A sub-provider need not comply with (A), (C), (D) or (H) of subsection (a)(1) of this Section.

B) The license of the parent organization may not be jeopardized or disciplined as a result of the actions of the sub-provider.

3) The appraisal education sub-provider, on each application for CE course approval, must certify:

A) The sub-organization has reviewed the CE course and approves the course content;

B) The sub-organization is an authorized affiliate of the parent organization;

C) The parent organization has given the sub-organization permission to seek course approval (licensure) under the umbrella of the parent organization's provider's license; or, that the parent organization will recognize the course for CE credit within its own CE program.

4) Each CE course sub-provider shall issue to each registered student a certificate of attendance that shall indicate the student's name, social security number or appraiser license/certification number, the date(s) and location of the course, the signature of an authorized representative of the sub-provider and a statement that the student did or did not attend a minimum of 90% of the course. A certificate of attendance may be in the form of a course attendance diploma, a certification letter, an official transcript or a "Uniform Request for Continuing Education Credit".

5) Within twenty-one (21) days after completion of each CE course presentation, the sub-provider shall certify to the Department, Office of the Appraisal Administrator, a roster of all duly registered students. The certification shall be on forms provided by the Department and shall include:

A) The CE course license number;

B) The license number of the parent provider;

C) The date(s) and location of the CE presentation;

D) The name of the instructor(s);

E) A listing of students by full name, appraiser license/certification number (or social security number) and an indication that the student did or did not attend a minimum of 90% of the course (the names shall be listed in alphabetical order); and

F) The authorized signature of a representative of the sub-organization.

c) Required Pre-License/Certification Course Curriculum

1) Standards of Professional Appraisal Practice--15 hours (IL I). This course curriculum reviews USPAP adopted by the Appraisal Subcommittee. Topics are:



A) Ethics Provision - USPAP
B) Competency Provision - USPAP
C) Departure Provision - USPAP
D) Standard 1 - USPAP
E) Standard 2 - USPAP
F) Standard 3 - USPAP
G) Standard 4 - USPAP
H) Standard 5 - USPAP
I) Standard 6 - USPAP

2) Basic Principles of Appraisal--30 hours (IL II). This course curriculum shall include an overview of the appraisal process covering the principles of market and valuation analysis necessary for appraising real property and an introduction to appraisal theory, concepts, techniques and the level of competence required to perform professional appraisal analyses. Topics are:

A) Influences on Real Estate
B) Real Estate/Real Property/Personal Property
C) Real Estate Ownership
D) Legal Descriptions
E) Types of Value
F) Economic Principles
G) Real Estate Markets and Market Analysis
H) Money and Capital Markets
I) Real Estate Financing
J) Valuation Process
K) Neighborhood Data and Analysis
L) Site Data and Analysis
M) Improvement Data and Analysis
N) Basic Construction and Design
O) Highest and Best Use Analysis
P) Sources of Valuation Data
Q) Accumulation of Valuation Data
R) Overview of the Three Approaches to Value
S) Reconciliation and Final Value Estimate
T) Overview of the Appraisal Report

3) Residential Valuation Procedures/Single Family Appraisal--30 hours (IL III). This course curriculum shall be designed to provide an understanding and working knowledge of the procedures and techniques required to estimate the market value of residential properties. Emphasis should be placed on the extraction of data and the correct application of the three approaches to real estate valuation. Topics are:

A) Basic Statistics
B) Residential Site Valuation - Sales Comparison
C) Residential Site Valuation - Allocation
D) Residential Site Valuation - Extraction
E) Cost Approach - Cost New Estimates

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F) Cost Approach - Entrepreneurial Profit
G) Cost Approach - Types of Depreciation
H) Cost Approach - Depreciation - Age-Life Method
I) Cost Approach - Depreciation - Market Extraction Method
J) Cost Approach - Depreciation - Breakdown Method
K) Cost Approach - Application
L) Sales Comparison Approach - Units of Comparison
M) Sales Comparison Approach - Elements of Comparison
N) Sales Comparison Approach - Cash Equivalency
O) Sales Comparison Approach - Making Adjustments
P) Sales Comparison Approach - Application
Q) Income Capitalization Approach - Gross Rent Estimates
R) Income Capitalization Approach - Gross Rent Multiplier
S) Income Capitalization Approach - Application
T) Residential Appraisal Reports

4) Valuation Procedures, Nonresidential Properties--30 hours (IL IV). This course curriculum focuses on the appraisal of nonresidential properties and provides a practical solution for estimating value by an in-depth study of appraisal theory and the development of advanced valuation skills. Topics are:
A) Basic Statistics
B) Site Valuation - Sales Comparison
C) Site Valuation - Allocation/Extraction
D) Site Valuation - Subdivision Analysis/Other Methods
E) Cost Approach - Cost New Estimates
F) Cost Approach - Entrepreneurial Profit
G) Cost Approach - Types of Depreciation
H) Cost Approach - Depreciation - Age-Life Method
I) Cost Approach - Depreciation - Market Extraction Method
J) Cost Approach - Depreciation - Breakdown Method
K) Cost Approach - Application
L) Sales Comparison Approach - Units of Comparison
M) Sales Comparison Approach - Elements of Comparison
N) Sales Comparison Approach - Cash Equivalency
O) Sales Comparison Approach - Making Adjustments
P) Sales Comparison Approach - Application
Q) Income Approach - Income Estimates
R) Income Approach - Expense Estimates
S) Income Approach - Capitalization Rates
T) Income Approach - Direct Capitalization
U) Income Approach - Income Multipliers
V) Income Approach - Application
W) Appraisal Reports

5) Income Capitalization--30 hours (IL V). Courses in this curriculum are to provide alternative methods of estimating present value based on income forecasts. There courses focus on more advanced capitalization methods and techniques. Topics include:



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A) Six Functions of $1
B) Gross Income Estimates
C) Vacancy and Collection Loss
D) Operating Expense Estimates
E) Reserves for Replacement
F) Operating Statement Ratios and Multipliers
G) Debt Service/Equity Dividend
H) Direct Capitalization
I) Overall Rate Development - Market Extraction
J) Overall Rate Development - Band of Investment
K) Overall Rate Development - Ratios/Multipliers
L) Overall Rate Development - Residual Techniques
M) Equity Dividend Rate
N) Debt Coverage Ratio
O) Cash Flow Estimates
P) Reversion Estimates
Q) Discount and Yield Rates
R) Yield Capitalization Overview
S) Discounted Cash Flow Analysis Overview
T) Lease Provisions, Analysis and Valuation
U) Lease Analysis
V) Partial Interest Valuation

6) Courses in the IL E curriculum (electives) are courses with topics that are considered more advanced; and/or cover appraisal topics not covered in the core course curricula. Credit for elective hours can be achieved by successful completion of courses approved in the IL E curriculum or by successful completion of courses with excess hours approved and allocated for elective credit in accordance with subsection (c)(9) of this Section.

7) Each pre-license/certification course shall be a minimum of 15 credit hours.

8) All pre-license/certification courses shall include a final examination.
A) Each final exam for curricula IL II, IL III, IL IV, IL V and IL E (elective) courses shall consist of a minimum of 50 questions; however, courses approved for 15 hours credit may have a final examination with 25 questions.
B) The final exam for IL I courses shall consist of a minimum of 25 questions.
C) The applicant shall pass the examination in order to obtain credit for a course. A passing score shall be a minimum of 70% of examination questions answered correctly.

9) If 80% of the required topics for IL II through IL V courses are presented, the course shall be approved for the minimum required hours. Two 15 hour courses from a single provider may be approved to meet a 30 hour curriculum requirement, provided the courses together cover a minimum of 80% of the required

curriculum topics. An application for one 15 hour course in a curriculum requiring 30 hours will be denied. For courses in the IL I curriculum 100% of the listed topics must be covered. IL E courses will be approved based upon the Committee's review of the course as to the value of topics to be presented and their relationship to the appraisal process.

A) Classroom hours in excess of the curriculum requirement may be approved for elective credit. Such approval is limited to 9 excess hours for courses in a 30 hour curriculum requirement and 5 excess hours for courses in a 15 hour curriculum requirement;

B) Excess hours may be approved, within the above limits based upon the Committee's evaluation of the appraisal educational value of the excess hours.

10) All changes in course content shall be submitted to the Department for review and evaluation.

11) The license for all pre-license/certification courses shall expire 36 months from the date of issue. An approved provider may renew the course approval by completing a renewal application and paying the renewal fee, in accordance with Sections 1455.300 ~~1455.210(b)(1)(A)~~ and 1455.305 ~~1455.300(c)~~ of this Part.

d) CE Course Requirement

1) Courses licensed by the Department for pre-license/certification appraiser education are approved for CE credit. The renewal applicant will be awarded credit for attendance at these courses provided the license for the course was valid and in good standing at the time of attendance; and provided the course is not repetitious as indicated by Section 1455.205. CE credit for pre-licensure certification education will be awarded as 15 hours for 15 hour courses and 20 hours for 30 (or more) hour courses.

2) CE courses shall be approved by the Appraisal Administrator, upon the recommendation of the Committee, for courses with or without a final examination.

3) The application for each course approval shall include a description of the course, a course (or instructor's) outline that shall list the time frame for topic presentation, the number of classroom instruction hours excluding examination, the time allotted for examination (if any), the specific course name as it will appear on transcripts or course certifications, a sample of the certificate, the transcript or other documentation that will be used to document the student's attendance and any other information that may be required by the Department.

A) An applicant may be required to submit texts and all other course materials for evaluation by the Appraisal Committee.

B) The application for CE courses being offered by a sub-provider shall also include a certification in accordance with subsection (b)(3) of this Section.

4) The Committee/Administrator shall approve courses that would



contribute to the integrity, extension and enhancement of professional skills and knowledge in the practice of Real Estate Appraisal. Courses submitted for approval should be designed to cover at least one of the following topics:

A) Ad Valorem Taxation
B) Arbitration
C) Business Courses (related to practice of real estate appraisal)
D) Construction Cost Estimating
E) Ethics and Standards of Professional Practice
F) Illinois Appraiser Licensing Laws and/or Rules
G) Land Use, Planning, and Zoning
H) Property Development
I) Real Estate Appraisal (valuation/evaluation)
J) Real Estate Management, Leasing, Brokerage, Timeshare
K) Real Estate Law
L) Real Estate Litigation
M) Real Estate Finance or Investment
N) Appraisal Computer Applications
O) Real Estate Securities and Syndications
P) Real Property Exchange
Q) Other topics deemed appropriate by the Committee/Administrator.

5) The Committee/Administrator shall not approve:

A) Motivation courses or seminars
B) Courses that focus instruction to increase appraiser income
C) Courses or seminars that focus on the recruitment of employees or clients
D) Courses or seminars with instructional material relative to associations
E) Courses or seminars with instructional material relative to passing the State's appraiser examination
F) Having less than three classroom hours of instruction exclusive of examination (if any)
G) A course for more than 20 hours CE credit

6) Subsequent to approval of any CE course, revisions in course content and/or course material shall be submitted for re-evaluation and re-approval. Failure to report course changes may result in revocation of the CE course license. The fee for re-approval shall be in accordance with Section 1455.305 ~~1455.210~~.

7) Approval (license) for CE courses shall expire on March 31 of even numbered years. The provider or sub-provider may renew the approval (license) by completing a renewal application and paying the renewal fee, in accordance with Sections 1455.300 ~~1455.210(b)(2)(A)~~ and 1455.305 ~~1455.300(d)~~ of this Part.

e) Audits and Inspections. The Department may conduct on site inspections of the course provider's (or sub-provider's) place of

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business and may audit any session of any course approved for pre-license or CE credit.

1) At the request of the Appraisal Administrator, a course provider shall provide a list of all courses that the provider is planning to offer within a 6 month period subsequent to the request. The list shall include the name and license number of each course, as well as the date, time and location of each presentation.

2) In the event of a course audit, the provider shall provide the Department representative, at no cost, any and all course materials used in the presentation of the course being audited.

3) The Appraisal Administrator, a member of the Administrator's staff, an Appraisal committee member or other designated Department employee may inspect the business office of any course provider (or sub-provider) during normal business hours.

f) Withdrawal of Approval

1) The Department, upon recommendation of the Real Estate Appraisal Committee, shall withdraw, suspend or place on probation in accordance with 68 Ill. Adm. Code 1110 the approval of the real estate appraiser education provider when the quality of the program fails to continue to meet the established criteria of an approved provider as set out in this Section or upon determination that the decision to approve the program was based upon false or deceptive information.

2) The provider's license will terminate immediately upon the failure to renew. Course licenses will terminate upon the expiration date or immediately upon the termination of the provider's license. The provider may thereafter reapply for approval as an appraiser education provider and for course approval.

(Source: Amended at 19 Ill. Reg. 16604, effective DEC 01 1995)

**Section 1455.210 Fees - Education Providers/Courses (Repealed)**

~~a) Application/Renewal Fees for Appraiser Education Providers~~

~~1) The fee for application as a real estate appraiser education provider shall be $1000, plus course approval fees set forth in subsection (b) below, which are non-refundable.~~

~~2) The fee for renewal of an approved real estate appraiser education provider shall be $500 per year which is non-refundable.~~

~~A) The fee to renew an appraiser education provider license that has expired for less than 60 days shall be $500 plus a penalty of $100.~~

~~B) An appraiser education provider's license that has expired for more than 60 days may not be renewed. The provider may reapply for licensure in accordance with Section 1455.200.~~



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~~b) Application Fees for Pre-license/certification and CE Course Approval~~

~~1) The application fee for a pre-license/certification appraisal course shall be $500 and each approved course will expire 3 years from the date of issue, or, upon the expiration of the provider license (for which the course license is subordinate).~~

~~A) The course may be renewed (subject to a valid provider's license) for an additional 3 years by completion of a renewal application provided by the Department and payment of a non-refundable renewal fee of $250.~~

~~B) Renewal applications received after the expiration date shall be $300. Applications received 366 days or more after the expiration date shall not be renewed. The applicant may submit a new application for approval of the pre-license/certification course under a different course title.~~

~~C) The renewal application shall include a confirmation of the provider's original certification and a certification that the course is essentially the same course as previously approved. In addition to the application, the applicant must explain any course revisions in detail, submit a listing of texts and other materials used in the course as well as the current final examination and the current course outline, which shall contain a time schedule for topic presentation.~~

~~2) The application fee for CE course approval shall be $300 and the approval (license) for each course may be renewed prior to its expiration date, which is March 31 of even numbered years. A course meeting the requirements of a pre-license/certification course as set forth in Section 1455.200(c)(1) through (5) will be denied licensure as a CE course; however, such course may be approved by application for approval as a pre-license/certification course and payment of the appropriate fee.~~

~~A) The CE course may be renewed for an additional 2 year licensure term by completion of a renewal application which shall be provided by the Department and payment of a renewal fee of $150.~~

~~B) The renewal fee, if submitted after the expiration date, shall be $200. Any application for CE course renewal received by the Department 366 days or more after the expiration date shall not be renewed. The applicant may submit a new application for approval of the course under a different course title.~~

~~C) The renewal application shall include a confirmation of the provider's original certification and a certification that the course is essentially the same course as previously approved. In addition to the application, the applicant must explain any course revisions in detail, submit a~~

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~~listing--of-texts-and-other-materials-used-in-the-course-and the-current-course--outline,--which--shall--contain--a--time schedule-for-topic-presentation.~~

~~3)~~ ~~The--fee-for-evaluation-of-revisions-to-approved-courses-shall-be $200--for--pre-license/certification--courses--and--$75--for---CE courses.~~

(Source: Repealed at 19 Ill. Reg. 16604, effective DEC 0 1 1995)

SUBPART C: GENERAL

**Section 1455.300 Renewals**

a) Every license or certificate issued under the Act as a State Licensed Real Estate Appraiser, Certified Residential Real Estate Appraiser or Certified General Real Estate Appraiser shall expire on September 30 of each odd-numbered year. The holder of a license or certification may renew the license or certification during the month preceding the expiration date by paying the required fee specified in Section 1455.305 of this Part. ~~36.6 of the Act.--A penalty fee of $20 shall be charged for renewal of an expired license or certification.~~

1) In order to renew a license or certification in 1995, and thereafter, an applicant will be required to comply with the continuing education requirements pursuant to Section 36.17 of the Act and Section 1455.205 of this Part.

2) A license with the title of State Licensed Real Estate Appraiser may be renewed by providing evidence of completion of experience as required by Section 1455.20(b), evidence of 20 hours CE course work and payment of renewal fees set forth in Section 1455.305 of this Part. ~~36.6--of--the--Act.~~ For a license expired between 2 years and 3 years, a renewal applicant shall complete the 20 hours of CE after the expiration date on the license.

3) An expired license for Certified Residential or General Real Estate Appraiser may be renewed by payment of renewal fees set forth in Section 1455.305 of this Part ~~36.6 of the Act~~ and evidence of completion of 20 hours of CE coursework. For a license expired between 2 years and 3 years, a renewal applicant shall complete 20 hours of CE after the expiration date on the license.

4) A license or certificate for State Licensed, Certified Residential or Certified General Real Estate Appraiser expired for more than 3 years will not be renewed. The appraiser may reapply for license or certification by meeting the licensure or certification requirements in effect at the time of application and by passing the appropriate State Appraiser Examination.

5) The holder of a license or certificate for State Licensed, Certified Residential or Certified General Appraiser that is expired for a period of less than 3 years may renew the license or certificate in accordance with the provisions of this Section. Licensees may not reapply for licensure or certification in the same appraiser category until the certificate has been expired for 3 years.

b) Approved real estate appraiser education providers shall renew December 31 each year by paying the required fee set forth in Section 1455.305 ~~1455.210(b)~~ of this Part. An appraiser education provider's license that has expired for more than 60 days may not be renewed. The provider may reapply for licensure in accordance with Section 1455.200.

c) Approved pre-license/certification courses will expire 3 years from the date of issue, or upon the expiration of the provider license (for which the course license is subordinate), and may be renewed by renewal application ~~reapplication~~ and payment of fees, in accordance with Sections ~~Section~~ 1455.200 and 1455.305 ~~1455.210~~, 60 days prior to expiration.

1) The renewal application shall include a confirmation of the provider's original certification and a certification that the course is essentially the same course as previously approved. In addition to the application, the applicant must explain any course revisions in detail, submit a listing of texts and other materials used in the course as well as the current final examination, and submit the current course outline, which shall contain a time schedule for topic presentation.

2) Applications received 366 days or more after the expiration date shall not be renewed. The applicant may submit a new application for approval of the pre-license/certification course under a different course title.

d) Approved appraisal CE courses will expire on March 31 of even numbered years and may be renewed by renewal application ~~reapplication~~ and payment of fees, in accordance with Sections ~~Section~~ 1455.200 and 1455.305 ~~1455.210~~, 60 days prior to expiration.

1) The renewal application shall include a confirmation of the provider's original certification and a certification that the course is essentially the same course as previously approved. In addition to the application, the applicant must explain any course revisions in detail, submit a listing of texts and other materials used in the course, and submit the current course outline, which shall contain a time schedule for topic presentation.

2) Any application for CE course renewal received 366 days or more after the expiration date shall not be renewed. The applicant may submit a new application for approval of the course under a different course title.

3) A course meeting the requirements of a pre-license/certification course as set forth in Section 1455.200(c)(1) through (5) will be denied licensure as a CE course; however, such course may be



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approved by application for approval as a pre-license/certification course and payment of the appropriate fee.

e) It is the responsibility of each individual holding certification or licensure to notify the Department of any change of address. Failure to receive a renewal form from the Department shall not constitute an excuse for failure to pay the renewal fee and to renew the certification in a timely manner.

f) A certificate for State Licensed Real Estate Appraiser will not be renewed until the Department has received documentation of 500 hours of experience in accordance with Section 1455.20(b). To expedite processing, the documentation may be submitted with the original application for licensure or as soon as the experience is met; otherwise, it shall be submitted with the renewal application.

Source: Amended at 19 Ill. Reg. 16604, effective DEC 01 1995)

**Section 1455.305 Fees**

a) Appraiser Application Fees
   1) The application fee for licensure as a State licensed real estate appraiser (whether by examination, examination acceptance, or reciprocity) is $175, effective December 1, 1995.
   2) The application fee for licensure as a Certified General or Certified Residential Real Estate Appraiser (whether by examination, examination acceptance, or reciprocity) is $175, effective December 1, 1995.
   3) The initial registry fee for original permanent licensure/certification as an appraiser is $75, effective December 1, 1995.
   4) The fee for each temporary practice permit, in accordance with Section 1455.70, is $100, effective December 1, 1995.
   5) The fee for extension of a temporary practice permit, in accordance with Section 1455.70, is $100, effective December 1, 1995.

b) Appraiser Renewal Fees
   1) The fee for renewal of an active appraiser license or certification is $450, effective December 1, 1995.
   2) The fee for renewing an expired license or certification is $550, effective December 1.

c) Application/Renewal Fees for Appraiser Education Providers
   1) The fee for application as a real estate appraiser education provider shall be $1000, plus necessary course approval fees as set forth in subsection (d) below.
   2) The fee for renewal as an approved real estate appraiser education provider shall be $500 per year.
   3) The fee to renew an appraiser education provider license that has



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been expired for less than 61 days shall be $600.

d) Application/Renewal Fees for Pre-license/Certification and CE Course Approval
   1) The application fee for approval of a pre-license/certification appraisal course shall be $500.
      A) The fee for renewal of a pre-license/certification appraisal course shall be $250.
      B) The fee for renewal of a pre-license/certification appraisal course that has been expired for less than 366 days shall be $350.
   2) The application fee for CE course approval shall be $300.
      A) The fee for renewal of an approved CE course shall be $150.
      B) The renewal fee for an approved CE course that has been expired for less than 366 days shall be $250.
   3) The fee for evaluation of revisions to approved courses shall be $200 for pre-license/certification courses and $75 for CE courses.

e) General
   1) All fees paid pursuant to the Act and this Section are non-refundable.
   2) Applicants for examination and reexamination for appraiser certification and licensing shall pay a fee covering the cost of providing such examination. If a designated testing service is utilized for the examination, such fee shall be paid directly to the designated testing service.
   3) The fee for certification of a registrant's record (e.g., license status, examination information, discipline, etc.) is $25.
   4) There is no fee for license/certification verification.
   5) The fee for issuance of a duplicate license or certification or replacement of a lost license or certification is $25.
   6) The fee for a license or certification with name and/or address change (other than name and/or address change at renewal) is $25.
   7) The fee for a decorative wall certificate is the actual cost of the certificate which shall include shipping and handling costs.
   8) The fee for a roster of persons licensed under the Act is the cost of producing the roster including shipping and handling costs.
   9) The fee for requesting a waiver of the real estate appraiser experience requirement pursuant to Section 36.11 of the Act shall be $25.
   10) The fee for furnishing a record of proceedings under Section 36.20 of the Act is $1 per page of the record.
   11) National Registry fees payable to the Appraisal Subcommittee pursuant to federal regulations and laws shall be paid by the agency from funds appropriated by the General Assembly from the Appraisal Administration Fund.

Source: Added at 19 Ill. Reg. 16604, effective

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1) Heading of the Part: Real Estate License Act of 1983

2) Code Citation: 68 Ill. Adm. Code 1450

3) Section Numbers: Adopted Action:

1450.45 New Section

4) Statutory Authority: Subpart A implementing Section 9 and Section 15 of the Real Estate License Act of 1983 [225 ILCS 455/9 and 15] (see P.A. 89-23, effective July 1, 1995), and authorized by Section 60(7) of the Civil Administrative Code of Illinois [20 ILCS 2150/60(7)]; Subpart B implementing Sections 4(17) and 11 of the Real Estate License Act of 1983 [225 ILCS 445/4(17) and 11] (see P.A. 89-23) and authorized by Section 60(7) of the Civil Administrative Code of Illinois [20 ILCS 2105/60(7)].

5) Effective Date of Rulemaking: December 1, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: August 7, 1995

9) Notice of Proposal Published in Illinois Register: August 18, 1995, 19 Ill. Reg. 11770

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version: Technical and formatting changes recommended by the Administrative Code Division and JCAR were incorporated in the final version.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? All the changes agreed upon by the Agency and JCAR have been made.

13) Will this amendment replace an emergency amendment currently in effect? Yes

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking: Section 1450.45 sets forth the regulatory fee structure for licensees under the Illinois Real Estate License Act of 1983. P.A. 89-23, effective July 1, 1995, repealed statutory fees specified in the Act and provided instead that fees be set by rule by the Commissioner. The proposed rules implement that statutory change.

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16) Information and questions regarding this adopted amendment shall be directed to:

Name: John Arthur
Office of the Commissioner of Savings and Residential Finance
500 East Monroe, Suite 800
Springfield, Illinois 62701-1509
Telephone: 217/782-6181

The full text of the Adopted Amendment begins on the next page:



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NOTICE OF ADOPTED AMENDMENTS

TITLE 68: PROFESSIONS AND OCCUPATIONS
CHAPTER VII: DEPARTMENT OF PROFESSIONAL REGULATION
SUBCHAPTER b: PROFESSIONS AND OCCUPATIONS

PART 1450
REAL ESTATE LICENSE ACT OF 1983

SUBPART A: GENERAL RULES



SUBPART B: SCHOOL RULES

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AUTHORITY: Subpart A implementing Sections 9 and 15 of the Real Estate License Act of 1983 [225 ILCS 455/9 and 15] (see P.A. 89-23, effective July 1, 1995), and authorized by Section 60(7) of the Civil Administrative Code of Illinois [20 ILCS 2105/60(7)]; Subpart B implementing Sections 4(17) and 11 of the Real Estate License Act of 1983 [225 ILCS 445/4(17) and 11] (see P.A. 89-23) and authorized by Section 60(7) of the Civil Administrative Code of Illinois [20 ILCS 2105/60(7)].

SOURCE: Rules and Regulations for the Administration of the Real Estate Brokers and Salesmen License Act (General Rules), effective December 4, 1974; Rules and Regulations for the Administration of the Real Estate Brokers and Salesmen License Act (School Rules), effective July 29, 1974; amended at 3 Ill. Reg. 885, effective February 2, 1979; amended at 4 Ill. Reg. 195, effective August 12, 1980; amended at 5 Ill. Reg. 5343, effective May 6, 1981; amended at 5 Ill. Reg. 8541, effective August 10, 1981; codified at 5 Ill. Reg. 11064; emergency amendment at 6 Ill. Reg. 916, effective January 6, 1982, for a maximum of 150 days; emergency amendment at 6 Ill. Reg. 2406, effective February 3, 1982, for a maximum of 150 days; amended at 6 Ill. Reg. 8221, effective July 1, 1982; amended at 9 Ill. Reg. 341, effective January 3, 1985; transferred from Chapter I, 68 Ill. Adm. Code 450 (Department of Registration and Education) to Chapter VII, 68 Ill. Adm. Code 1450 (Department of Professional Regulation) pursuant to P.A. 85-225, effective January 1, 1988, at 12 Ill. Reg. 2977; amended at 12 Ill. Reg. 8036, effective April 26, 1988; amended at 15 Ill. Reg. 10416, effective July 1, 1991; amended at 16 Ill. Reg. 3204, effective February 14, 1992; emergency amendment at 19 Ill. Reg. 12003, effective August 8, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 16623, effective DEC 01 1995.

SUBPART A: GENERAL RULES

**Section 1450.45 Fees**

a) License of real estate salesperson.
   1) The fee for an initial license as a salesperson is $100. The fee must accompany the application to determine the applicant's fitness to receive a license.
   2) The fee for renewal of a salesperson's license which has not expired shall be calculated at the rate of $25 per year.
   3) The fee for the renewal of a salesperson's license which has been expired for not more than 5 years, as provided for in Section 13.2 of the Act, is the sum of all lapsed renewal fees plus $50.

b) License of Broker.
   1) The fee for an initial license as a broker is $100. The fee must accompany the application to determine an applicant's fitness to receive a license.
   2) The fee for the renewal of a broker's license which has not expired shall be calculated at the rate of $50 per year.
   3) The fee for the renewal of a broker's license which has been expired for not more than 5 years, as provided for in Section 13.2 of the Act, is the sum of all lapsed renewal fees plus $50.

c) License of partnership, limited liability company, or corporation.
   1) The fee for an initial license for a partnership, limited liability company, or corporation is $100. The fee must accompany the application to determine an applicant's fitness to receive a license.
   2) The fee for the renewal of a license for a partnership, limited liability company, or corporation shall be calculated at the rate of $50 per year.
   3) The fee for the renewal of a license for a partnership, limited liability company or corporation which has been expired is the sum of all lapsed renewal fees plus $50.

d) License for Branch Office.
   1) The fee for an initial license for a branch office is $100. The fee must accompany the application to determine an applicant's fitness to receive a license.
   2) The fee for the renewal of a branch office license shall be calculated at the rate of $50 per year.
   3) The fee for the renewal of a branch office license which has been expired is the sum of all lapsed renewal fees plus $50.

e) Real Estate School and Instructor Fees.
   1) The fee for an application for initial approval of a private, business, or vocational real estate school is $1,000. The fee must accompany the application to determine an applicant's fitness to receive a license.
   2) The fee for renewal of approval of a private, business, or vocational real estate school shall be calculated at the rate of $500 per year.
   3) The fee for the renewal of approval of a private, business, or vocational real estate school which has been expired is the sum of all lapsed renewal fees plus $50.
   4) The fee for an application for initial approval of a branch for a private, business, or vocational real estate school is $150 per branch. The fee must accompany the application to determine an



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applicant's fitness to receive approval.

5) The fee for renewal of approval of a branch for a private, business, or vocational real estate school shall be calculated at the rate of $75 per branch per year.

6) The fee for the renewal of approval of a branch for a private, business, or vocational real estate school which has been expired is the sum of all lapsed renewal fees plus $50.

7) The fee for transferring a branch location shall be $25 per transfer.

8) The fee for application for initial approval of a private, business, or vocational real estate school instructor is $50. The fee must accompany the application to determine the applicant's fitness for approval.

9) The fee for renewal of approval of a private, business, or vocational real estate school instructor shall be calculated at the rate of $25 per year.

10) The fee for the renewal of approval of a private, business, or vocational real estate school instructor which has been expired is the sum of all lapsed renewal fees plus $50.

f) Continuing Education Sponsor and Instructor Fees.

1) The fee for an application for initial approval as a continuing education sponsor shall be $2,000. The fee must accompany the application to determine an applicant's fitness for approval.

2) The fee for renewal of approval as a continuing education sponsor shall be $2,000.

3) The fee for renewal of approval as a continuing education sponsor which has expired shall be the sum of all lapsed renewal fees plus $50.

4) The fee for an application for initial approval as a continuing education instructor shall be $15. The fee must accompany the application to determine an applicant's fitness to receive approval.

5) The fee for renewal of approval as a continuing education instructor shall be $15.

6) The fee for the renewal of approval as a continuing education instructor which has been expired is the sum of all lapsed renewal fees plus $50.

g) General.

1) All fees paid pursuant to the Act and this Section are non-refundable.

2) The fee for the issuance of a duplicate license or pocket card, for the issuance of a replacement license or pocket card for a license or pocket card which has been lost or destroyed, for the issuance of a license with a change of name or address other than during the renewal period, or for the issuance of a license with a change of location of business is $25.

3) The fee for a certification of a licensee's record for any purpose is $25.



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4) The fee for a wall license showing registration shall be the cost of producing such license.

5) The fee for a roster of persons licensed as brokers or sales persons in this State shall be the cost of producing such a roster.

6) Applicants for an examination as a broker, salesperson, or real estate instructor shall be required to pay a fee covering the cost of providing the examination. If a designated testing service is utilized for the examination, such fee shall be paid directly to the designated testing service. Failure to appear for the examination on the scheduled date, at the time and place specified, after the applicant's application for examination has been received and acknowledged, shall result in the forfeiture of the examination fee.

7) The fee for requesting a waiver of continuing education requirements pursuant to Section 37.8 of the Act shall be $25.

8) The fee for processing a sponsor card other than at the time of original licensure is $25.

9) The fee for furnishing a record of proceedings provided for in subsection (h) of Section 20 of this Act or for certifying the record referred to in Section 21 of the Act is $1 per page of the record.

10) Pursuant to Section 15 of the Act, the fee for an initial license and a renewal license for real estate salespersons and real estate brokers shall include a $10 fee for deposit in the Real Estate Recovery Fund and a $5 fee for deposit in the Real Estate Research and Education Fund.

11) Pursuant to Section 15 of the Act, the fee for an initial license for a partnership or corporation shall include a $10 fee for deposit in the Real Estate Recovery Fund and a $5 fee for deposit in the Real Estate Research and Education Fund.

12) Pursuant to Section 15 of the Act, the fee for an initial license for a branch office shall include a $5 fee for deposit in the Real Estate Research and Education Fund.

(Source: Added at 19 Ill. Reg. 16623, effective DEC 01 1995)

DEPARTMENT OF PUBLIC AID

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Hospital Services

2) Code Citation: 89 Ill. Adm. Code 148

3) Section Numbers: Adopted Action:

| | |
|---|---|
| 148.120 | Amendment |
| 148.140 | Amendment |
| 148.160 | Amendment |
| 148.170 | Amendment |
| 148.295 | New Section |
| 148.310 | Amendment |

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/12-13]

5) Effective Date of Amendments: November 28, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Do these Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: November 28, 1995

9) Notice of Proposal Published in Illinois Register: July 21, 1995 (19 Ill. Reg. 10387)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

11) Differences between proposal and final version: The following changes have been made in the proposed amendments.

Section 148.140

In subsection (a)(6), the comma after "148.25(b)(2)(B)" has been stricken, and "within 90 days of" has been changed to "within 90 days after".

Subsection (b)(5) has been revised to read, "County Facility Outpatient Adjustment".

In the first sentence of subsection (b)(5)(A), "Illinois County" has been changed to "Illinois county".

Section 148.160

In subsection (f)(2), "89 Ill. Adm. Code 149.50(c)(8)" has been changed to "subsection (a) above".



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In subsection (f)(2)(D), the comma after "subsection (f)(2) above" has been deleted.

In subsection (f)(4), the second sentence has been revised to read:

> Effective with admissions on or after July 1, 1995, supplemental inpatient payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for inflation, as described in subsection (d) above, and the sum of the calculated disproportionate share and Medicaid percentage per diem payments as described in Section 148.120 and subsection (f)(2) above, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992.

Section 148.295

In the introduction to Section 148.295, a comma has been added after "Section 148.25 (b)(1)(B)".

In subsection (a)(1)(A), a comma has been added after "CHAP rate period" and the comma after "Illinois Department of Public Health" has been deleted.

Subsection (a)(3)(B) has been revised to read:

> (B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the last day of June preceding the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(3)(A) above; or the hospital is not located in a HPSA (42 CFR 5) and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(3)(A) above.

In subsections (b)(1) and (2), "89 Ill. Adm. Code 149.50(c)(2)," has been replaced by "subsection (b) above".

Subsection (b)(3) has been revised to read:

> (3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) above, that are located in a Health Professional Shortage Area (HPSA) (42 CFR 5) as of the last day of June preceding the CHAP rate period, shall receive $300.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.

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Subsection (c) has been revised by deleting the period after "Direct Hospital Adjustment (DHA) Criteria" and moving the next sentence into an introductory paragraph.

Subsection (c)(1) has been revised to read:

(1) Be an Illinois hospital located outside of Health Service Area (HSA) six that meets one of the following criteria:

A) Has a Medicaid inpatient utilization rate on the last day of June preceding the CHAP rate period, as defined in Section 148.120(k)(5), greater than 60 percent and has an average length of stay of less than ten days.

B) Is a major teaching hospital with 35 or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

In subsections (c)(2)(A)(i), (ii) and (iii), a comma has been added after "Hospitals that".

In subsection (c)(2)(A)(iii), the comma after "Section 148.120(g)(1) or (g)(2)" has been deleted.

In subsection (c)(2)(A)(v), the beginning of the second sentence has been revised to read, "If the hospital's Medicaid obstetrical care". In the same sentence, a comma has been added after "in their planning area".

Subsection (c)(2)(A)(vi) has been revised to read:

(vi) Hospitals that on the last day of June preceding the CHAP rate period have a Medicaid inpatient utilization rate as defined in Section 148.120(k)(5) which is equal to or greater than one-half a standard deviation above the mean Medicaid inpatient utilization rate in their planning area, shall receive a critical weighting factor of ten. If the hospital's Medicaid inpatient utilization rate is greater than the mean but less than one-half a standard deviation above the mean Medicaid inpatient utilization rate in their planning area, the hospital shall receive a critical weighting factor of five.

The beginning of the second sentence of subsection (c)(2)(A)(vii) has been changed to "If the hospital's Medicaid". In the same sentence, a comma has been added after "in their planning area".

The beginning of the second sentence of subsection (c)(2)(A)(viii) has been changed to "If the hospital's cost". In the same sentence, a comma has been added after "in their planning area".



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In subsection (c)(2)(B), "American Dental Association Joint Commission of Dental Accreditation" has been changed to "American Dental Association Joint Commission on Dental Accreditation".

In subsection (c)(2)(C), "3,500" has been changed to "3,400".

In subsection (c)(3), "2,500" has been changed to "2,400".

At the end of subsection (c)(4), "American Dental Association Joint Commission of Dental Accreditation" has been changed to "American Dental Association Joint Commission on Dental Accreditation".

Subsection (d) has been revised by deleting the period after "DHA Adjustment" and moving the following text into an introductory paragraph.

In subsection (d)(1), "subsection (c)(1)" has been changed to "subsection (c)(1)(A)", and "EHA" has been changed to "DHA".

In subsection (d)(2), "subsection (c)(2) or (c)(5)" has been changed to "subsection (c)(1)(B), (c)(2) or (c)(5)".

In subsection (d)(3), "eighty-five" has been changed to "85".

In subsection (d)(5), commas have been added after both occurrences of "on the last day of June preceding the CHAP rate period", and both occurrences of "fifty" have been changed to "50".

Subsection (f) has been revised by deleting the period after "Critical Hospital Adjustment Limitations" and moving the following text into an introductory paragraph.

Subsection (g) has been revised by deleting the period after "Critical Hospital Adjustment Payment Definitions" and moving the following text into an introductory paragraph.

In subsection (g)(1), the comma after "State Fiscal Year 1994" has been deleted, and the commas after both occurrences of "Chap rate period" have been changed to semicolons.

In subsection (g)(3), both "Eighty" and "eighty" have been changed to "80".

At the end of subsection (g)(10), "level II" has been changed to "Level II".

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Section 148.310

The second sentence of subsection (i)(1) has been revised to read, "Hospitals shall be notified in writing of the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if it is believed that a technical error has been made in the calculation."

The introduction to subsection (i)(2)(A) has been revised to read, "Federally Designated Health Professional Shortage Areas (HPSAs)."

In subsection (i)(2)(A), all references to "HMSA" or "HMSAs" have been changed to "HPSA" or HPSAs". Additionally, the CFR citation has been changed to "42 CFR 5".

The beginning of the first sentence of subsection (i)(2)(H) has been revised to read, "Graduate Medical Education program information shall be".

Also in subsection (i)(2)(H), "American Dental Association Joint Commission of Dental Accreditation" has been changed to "American Dental Association Joint Commission on Dental Accreditation".

No other changes have been made in the text of the proposed amendments.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Amendments replace Emergency Amendments currently in effect? Yes

14) Are there any Amendments pending on this Part? Yes

| Section Numbers | Proposed Action | Illinois Register Citation |
|---|---|---|
| 148.210 | Amendment | September 22, 1995 (19 Ill. Reg. 13199) |

15) Summary and Purpose of Amendments: These amendments describe changes in reimbursement methodologies for hospital services covered under the Medical Assistance Program. The Department is initiating the changes found in Sections 148.120 through 148.170 to maximize the availability of federal matching funds (FFP) to hospitals as permitted by Illinois' federal disproportionate share (DSH) spending limitations and federal upper limits. The changes are intended to increase funding for hospital services and improve services for Medicaid recipients, while complying with the budget plan for fiscal year 1996. These rate changes for hospital services are consistent with current reimbursement methodologies



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and ensure compliance with federal regulations.

In Sections 148.120, 148.140 and 148.160, changes affect rates of reimbursement for county-owned hospitals in Illinois counties which have populations greater than three million. Section 148.120 describes revisions to the DSH adjustment calculation which meet requirements found in Public Law 103-66. Section 148.140 has been revised by the addition of a county facility outpatient rate adjustment. Section 148.160 has been revised to reflect a Medicaid percentage adjustment, a critical inpatient adjustment, and a redefinition of the supplemental DSH adjustment as an inpatient adjustment.

Changes to Section 148.170, which addresses reimbursement for hospitals organized under the University of Illinois Hospital Act, affect the multiplier for the DSH calculation.

Additionally, the Department is also initiating the implementation of a critical hospital adjustment payment, as described in Section 148.295. Hospitals meeting certain criteria, but excluding county-owned hospitals and hospitals organized under the University of Illinois Hospital Act, are eligible for this payment adjustment. These payments recognize and ensure the availability of critical hospital services, including trauma care, perinatal care, obstetrics, rehabilitation and pediatrics. Hospitals with high Medicaid utilization and high occupancy levels also qualify for critical hospital adjustment payments. These provisions respond to Public Act 89-21 which allows the Department to establish criteria for the payment adjustment methodology described in Section 148.295. Review procedures regarding critical hospital adjustment payments, are detailed in Section 148.310.

These amendments are expected to result in an annual increase in Department expenditures of approximately $550.6 million; approximately one-half of that amount is FFP.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Joanne Jones
Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor
Springfield, IL 62762
(217) 524-3215

The full text of the Adopted Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 148
HOSPITAL SERVICES

Section
148.10 Hospital Services
148.20 Participation
148.25 Definitions and Applicability
148.30 General Requirements
148.40 Special Requirements
148.50 Covered Hospital Services
148.60 Services Not Covered as Hospital Services
148.70 Limitation On Hospital Services
148.80 Organ Transplants Services Covered Under Medicaid (Repealed)
148.82 Organ Transplant Services
148.90 Heart Transplants (Repealed)
148.100 Liver Transplants (Repealed)
148.110 Bone Marrow Transplants (Repealed)
148.120 Disproportionate Share Hospital (DSH) Adjustments
148.130 Outlier Adjustments for Exceptionally Costly Stays
148.140 Hospital Outpatient and Clinic Services
148.150 Public Law 103-66 Requirements
148.160 Payment Methodology for County-Owned Hospitals in a County with a Population of Over Three Million
148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act
148.175 Supplemental Disproportionate Share Payment Methodology for Hospitals Organized Under the Town Hospital Act
148.180 Payment for Pre-operative Days, Patient Specific Orders, and Services Which Can Be Performed in an Outpatient Setting
148.190 Copayments
148.200 Alternate Reimbursement Systems
148.210 Filing Cost Reports
148.220 Pre September 1, 1991 Admissions
148.230 Admissions Occurring on or after September 1, 1991
148.240 Utilization Review and Furnishing of Inpatient Hospital Services Directly or Under Arrangements
148.250 Determination of Alternate Payment Rates to Certain Exempt Hospitals
148.260 Calculation and Definitions of Inpatient Per Diem Rates
148.270 Determination of Alternate Cost Per Diem Rates for All Hospitals; Payment Rates for Certain Exempt Hospital Units; and Payment Rates for Certain Other Hospitals
148.280 Reimbursement Methodologies for Children's Hospitals and Hospitals Reimbursed Under Special Arrangements
148.290 Adjustments and Reductions to Total Payments



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148.295 Critical Hospital Adjustment Payments (CHAP)
148.300 Payment
148.310 Review Procedure
148.320 Alternatives
148.330 Exemptions
148.340 Subacute Alcoholism and Substance Abuse Treatment Services
148.350 Definitions
148.360 Types of Subacute Alcoholism and Substance Abuse Treatment Services
148.368 Volume Adjustment (Repealed)
148.370 Payment for Subacute Alcoholism and Substance Abuse Treatment Services
148.373 Utilization (Repealed)
148.376 Utilization, Case-Mix and Discretionary Funds
148.380 Rate Appeals for Subacute Alcoholism and Substance Abuse Treatment Services
148.390 Hearings
148.400 Special Hospital Reporting Requirements

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act [20 ILCS 2215/Art. III] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI and VII and 12-13].

SOURCE: Sections 148.10 thru 148.390 recodified from 89 Ill. Adm. Code 140.94 thru 140.398 at 13 Ill. Reg. 9572; Section 148.120 recodified from 89 Ill. Adm. Code 140.110 at 13 Ill. Reg. 12118; amended at 14 Ill. Reg. 2553, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 11392, effective July 1, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 15358, effective September 13, 1990; amended at 14 Ill. Reg. 16998, effective October 4, 1990; amended at 14 Ill. Reg. 18293, effective October 30, 1990; amended at 14 Ill. Reg. 18499, effective November 8, 1990; emergency amendment at 15 Ill. Reg. 10502, effective July 1, 1991, for a maximum of 150 days; emergency expired October 29, 1991; emergency amendment at 15 Ill. Reg. 12005, effective August 9, 1991, for a maximum of 150 days; emergency expired January 6, 1992; emergency amendment at 15 Ill. Reg. 16166, effective November 1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 18684, effective December 23, 1991; amended at 16 Ill. Reg. 6255, effective March 27, 1992; emergency amendment at 16 Ill. Reg. 11335, effective June 30, 1992, for a maximum of 150 days; emergency expired November 27, 1992; emergency amendment at 16 Ill. Reg. 11942, effective July 10, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 14778, effective October 1, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19873, effective December 7, 1992; amended at 17 Ill. Reg. 131, effective December 21, 1992; amended at 17 Ill. Reg. 3296, effective March 1, 1993; amended at 17 Ill. Reg. 6649, effective April 21, 1993; amended at 17 Ill. Reg. 14643, effective August 30, 1993; emergency amendment at 17 Ill. Reg. 17323, effective October 1, 1993, for a maximum of 150 days; amended at 18 Ill. Reg. 3450, effective February 28, 1994; emergency amendment at 18 Ill. Reg. 12853, effective August 2, 1994, for a maximum of 150 days; amended

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at 18 Ill. Reg. 14117, effective September 1, 1994; amended at 18 Ill. Reg. 17648, effective November 29, 1994; amended at 19 Ill. Reg. 1067, effective January 20, 1995; emergency amendment at 19 Ill. Reg. 3510, effective March 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 6709, effective May 12, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 10060, effective June 29, 1995; emergency amendment at 19 Ill. Reg. 10752, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13009, effective September 5, 1995; amended at 19 Ill. Reg. 16630, effective NOV 28 1995.

**Section 148.120 Disproportionate Share Hospital (DSH) Adjustments**

Disproportionate Share Hospital (DSH) adjustments for inpatient services provided prior to October 1, 1993, shall be determined and paid in accordance with the statutes and administrative rules governing the time period when the services were rendered. The Department shall make an annual determination of those hospitals qualified for adjustments under this Section effective October 1, 1993, and each October 1, thereafter unless otherwise noted.

a) Qualified Disproportionate Share Hospitals (DSH). For inpatient services provided on or after October 1, 1993, the Department shall make adjustment payments to hospitals which are deemed as disproportionate share by the Department. A hospital may qualify for a DSH adjustment in one of the following ways:

1) The hospital's Medicaid inpatient utilization rate, as defined in subsection (k)~~(t)~~(5) of this Section, is at least one half standard deviation above the mean Medicaid utilization rate, as defined in subsection (k)~~(t)~~(3) of this Section.

2) The hospital's low income utilization rate exceeds 25 per centum. For this alternative, payments for all patient services (not just inpatient) for Medicaid, Family and Children Assistance (formerly known as General Assistance), Aid to the Medically Indigent (AMI) and/or any local or state government-funded care, must be counted as a percentage of all net patient service revenue. To this percentage, the percentage of total inpatient charges attributable to inpatient charges for charity care (less payments for GA and AMI inpatient hospital services, and/or any local or state government-funded care) must be added.

3) Illinois hospitals that, on July 1, 1991, had a Medicaid inpatient utilization rate, as defined in subsection (k)~~(t)~~(5) of this Section, that was at least the mean Medicaid inpatient utilization rate, as defined in subsection (k)~~(t)~~(3) of this Section, and which were located in a planning area with one-third or fewer excess beds as determined by the Illinois Health Facilities Planning Board (77 Ill. Adm. Code 1100), and that, as of June 30, 1992, were located in a federally designated Health Manpower Shortage Area (42 CFR 5, 1989).

4) Illinois hospitals that:

A) Have a Medicaid inpatient utilization rate, as defined in subsection (k)~~(t)~~(5) of this Section, which is at least the mean Medicaid inpatient utilization rate, as defined in subsection (k)~~(t)~~(3) of this Section, and

B) Have a Medicaid obstetrical inpatient utilization rate, as defined in subsection (k)~~(t)~~(6) of this Section, that is at least one standard deviation above the mean Medicaid obstetrical inpatient utilization rate, as defined in subsection (k)~~(t)~~(4) of this Section.

5) Any children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's medical assistance care is provided to children.

b) In addition, to be deemed a DSH hospital, a hospital must provide the Department, in writing, with the names of at least 2 obstetricians with staff privileges at the hospital who have agreed to provide obstetric services to individuals entitled to such services under a State Medicaid plan. In the case of a hospital located in a rural area (that is, an area outside of a Metropolitan Statistical Area, as defined by the Executive Office of Management and Budget), the term "obstetrician" includes any physician with staff privileges at the hospital to perform nonemergency obstetric procedures. This requirement does not apply to a hospital in which the inpatients are predominantly individuals under 18 years of age; or does not offer nonemergency obstetric services as of December 22, 1987. Hospitals that do not offer nonemergency obstetrics to the general public, with the exception of those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4), must submit a statement to that effect.

c) In making the determination described in subsections (a)(1) and (a)(4)(A) above, the Department shall utilize:

1) The hospital's final audited cost report for the hospital's base fiscal year. Medicaid inpatient utilization rates, as defined in subsection (k)~~(t)~~(5) of this Section, which have been derived from final audited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation.

2) In the absence of a final audited cost report for the hospital's base fiscal year, the Department shall utilize the hospital's unaudited cost report for the hospital's base fiscal year. Due to the unaudited nature of this information, hospitals shall have the opportunity to submit a corrected cost report for the determination described in subsections (a)(1) and (a)(4)(A) above. Submittal of a corrected cost report in support of subsections (a)(1) and (a)(4)(A) above must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such corrected cost report for the determination of DSH qualification.



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Corrected cost reports which are not received in compliance with these time limitations will not be considered for the determination of the hospital's Medicaid inpatient utilization rate as described in subsection (k)~~(j)~~(5) of this Section.

A) Hospital's Medicaid inpatient utilization rates, as defined in subsection (k)~~(j)~~(5) of this Section, which have been derived from unaudited cost reports, are not subject to the Review Procedure described in Section 148.310, with the exception of errors in calculation. Pursuant to subsection (c)(2) above, hospitals shall have the opportunity to submit corrected cost report information prior to the Department's final DSH determination.

B) In the event a subsequent final audited cost report reflects a Medicaid inpatient utilization rate, as described in subsection (k)~~(j)~~(5) of this Section, which is lower than the Medicaid inpatient utilization rate derived from the unaudited cost report utilized for the DSH determination, the Department shall recalculate the Medicaid inpatient utilization rate based upon the final audited cost report, and recoup any overpayments made.

3) Certain types of inpatient days of care provided to Title XIX recipients are not available from the cost report, i.e., Medicare/Medicaid crossover claims, out-of-state Title XIX Medicaid utilization levels, Medicaid Health Maintenance Organization (HMO) days, hospital residing long term care days, and Department of Alcohol and Substance Abuse (DASA) Medicaid days. To obtain Medicaid utilization levels in these instances, the Department shall utilize:

A) Medicare/Medicaid Crossover Claims.

i) For DSH determination years on or after October 1, 1996, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year. Provider logs as described in the following subsection (c)(3)(A)(ii) will not be used in the determination process for DSH determination years on or after October 1, 1996.

ii) For DSH determination years prior to October 1, 1996, hospitals may submit additional information to document Medicare/Medicaid crossover days that were not billed to the Department due to a determination that the Department had no liability for deductible or coinsurance amounts. That information must be submitted in log form. The log must include a patient account number or medical record number, patient name, Medicaid recipient identification number, Medicare identification number, date of admission, date of discharge, the number of covered days, and the total



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number of Medicare/Medicaid crossover days. That log must include all Medicare/Medicaid crossover days billed to the Department and all Medicare/Medicaid crossover days which were not billed to the Department for services provided during the hospital's base fiscal year. If a hospital does not submit a log of Medicare/Medicaid crossover days that meets the above requirements, the Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for the hospital's applicable base fiscal year.

B) Out-of-state Title XIX Utilization Levels. Hospital statements and verification reports from other states will be required to verify out-of-state Medicaid recipient utilization levels. The information submitted must include only those days of care provided to out-of-state Medicaid recipients during the hospital's base fiscal year.

C) HMO days. The Department will utilize the Department's HMO claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient days provided to recipients enrolled in an HMO.

D) Hospital Residing Long Term Care Days. The Department will utilize the Department's paid claims data adjudicated through the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of hospital residing long term care inappropriate level of care days provided to recipients.

E) DASA Days. The Department will utilize the Department's DASA paid claims data available to the Department as of the last day of June preceding the DSH determination year for each hospital's base fiscal year to determine the number of inpatient DASA days provided.

d) Hospitals may apply for DSH status under subsection (a)(2) by submitting an audited certified financial statement for the hospital's base fiscal year. The Department of Mental Health and Developmental Disabilities must submit a statement, signed by the Director of that agency, certifying the accuracy of the data submitted for facilities operated by that agency. The statements must contain the following breakdown of information prior to submittal to the Department for consideration:

1) Total hospital net revenue for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

2) Total payments received directly from State and local governments for all patient services, both inpatient and outpatient, for the hospital's base fiscal year.

3) Total gross inpatient hospital charges for charity care (this must not include contractual allowances, bad debt or discounts,

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except contractual allowances and discounts for Family and Children Assistance, formerly known as General Assistance, and AMI patients), for the hospital's base fiscal year.

4) Total amount of the hospital's gross charges for inpatient hospital services for the hospital's base fiscal year.

e) With the exception of cost-reporting children's hospitals in contiguous states that provide 100 or more inpatient days of care to Illinois program participants, only those cost-reporting hospitals located in states contiguous to Illinois that qualify for DSH in the state in which they are located based upon the Federal definition of a DSH hospital, as defined in Section 1923(b)(1) of the Social Security Act, may qualify for DSH hospital adjustments under this Section. For purposes of determining the Medicaid inpatient utilization rate, as described in subsection (k)~~(i)~~(5) of this Section and as required in Section 1923(b)(1) of the Social Security Act, out-of-state hospitals will be measured in relationship to one standard deviation above the mean Medicaid inpatient utilization rate in their state. Out-of-state hospitals that do not qualify by the Medicaid inpatient utilization rate from their state may submit an audited certified financial statement as describe in subsection (d) above. Payments to out-of-state hospitals will be allocated using the same methods as described in subsection (g).

f) Time Limitation Requirements for Additional Information.

1) The information required in subsections (a)(2), (c), (d) and (e) must be received no later than the first day of July preceding the DSH determination year for which the hospital is requesting consideration of such information for the determination of DSH qualification. Information required in this Section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

2) The information required in subsection (b) must be received within 30 calendar days after receipt of notification from the Department that the information must be submitted. Information required in this Section which is not received in compliance with these limitations will not be considered for the determination of those hospitals qualified for DSH adjustments.

g) Inpatient Payment Adjustments to DSH Hospitals. The adjustment payments required by subsection (a) above shall be calculated annually as follows:

1) Five Million Dollar Fund Adjustment for hospitals defined in Section 148.25(b)(1).

A) Hospitals qualifying as DSH hospitals under subsection (a)(1) that have a Medicaid inpatient utilization rate, as described in subsection (k)~~(i)~~(5) of this Section, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, as described in subsection (k)~~(i)~~(3) of this Section, and hospitals qualifying as DSH



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hospitals under subsection (a)(2) of this Section will receive an add-on payment to their inpatient rate.

B) The distribution method for the add-on payment described in subsection (g)(1)(A) above is based upon a fund of $5 million. All hospitals qualifying under subsection (g)(1)(A) above will receive a $5 per day add-on to their current rate. The total cost of this adjustment is calculated by multiplying each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) by $5. The total dollar amount of this calculation is then subtracted from the $5 million fund.

C) The remaining fund balance is then distributed to the hospitals that qualify under subsection (a)(1) that have a Medicaid inpatient utilization rate, as described in subsection (k)~~(i)~~(5) of this Section, which is at least one standard deviation above the mean Medicaid inpatient utilization rate, above in proportion to the percentage by which the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the State's Medicaid inpatient utilization rate, as described in subsection (k)~~(i)~~(3) of this Section. This is done by finding the ratio of each hospital's percent Medicaid utilization to the State's mean plus one standard deviation percent Medicaid value. These ratios are then summed and each hospital's proportion of the total is calculated. These proportional values are then multiplied by each hospital's most recent completed fiscal year Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization). These weighted values are summed and each hospital's proportion of the summed weighted value is calculated. Each individual hospital's proportional value is then multiplied against the $5 million pool of money available after the $5 per day base add-on has been subtracted.

D) The total dollar amount calculated for each qualifying hospital under subsection (g)(1)(C) above, plus the initial$5 per day add-on amount calculated for each qualifying hospital under subsection (g)(1)(B) above, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at per day add-on value. Hospitals qualifying under subsection (a)(2), will receive the minimum adjustment of $5 per inpatient day. The adjustments calculated under this subsection are subject to the limitations described in subsection (j)~~(k)~~ of this Section.

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2) Medicaid Percentage Adjustment for hospitals defined in Section 148.25(b)(1), excluding hospitals defined in Section 148.25(b)(1)(A).
   A) In addition to the adjustment methodology described in subsection (g)(1) above, all DSH hospitals described in subsection (a)(1), (2), (3) (4), and (5) shall receive a payment adjustment which shall be calculated annually as follows:
   B) The payment adjustment shall be calculated based upon the hospital's Medicaid inpatient utilization rate, as defined in subsection (k)~~(1)~~(5) of this Section, and subject to subsections (h)~~,~~ and (i)~~,~~ ~~and (j)~~ below, as follows:
      i) Hospitals with a Medicaid inpatient utilization rate below the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25;
      ii) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than the mean Medicaid inpatient utilization rate but less than one standard deviation above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $25 plus $1 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds the mean Medicaid inpatient utilization rate;
      iii) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than one standard deviation above the mean Medicaid inpatient utilization rate but less than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $40 plus $7 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate; and
      iv) Hospitals with a Medicaid inpatient utilization rate that is equal to or greater than 1.5 standard deviations above the mean Medicaid inpatient utilization rate shall receive a payment adjustment of $90 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate exceeds one standard deviation above the mean Medicaid inpatient utilization rate.
   C) For ~~county-owned---hospitals,---as--described--in--Section 148.25(b)(1)(A),--or~~ a hospital organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), the amount calculated pursuant to subsection (g)(2)(B) above shall be increased by $60 per day.
   D) The Medicaid percentage adjustment payment, calculated in accordance with this subsection (g)(2), to a hospital, other than ~~county-owned---hospitals,--as--described--in--Section 148.25(b)(1)(A),--or~~ a hospital and/or hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25(b)(1)(B), shall not exceed $155 per day for a children's hospital, as described in subsection (a)(5) of this Section, and shall not exceed $215 per day for all other hospitals.
   E) The amount calculated pursuant to subsections (g)(2)(B) through (g)(2)(D) above shall be adjusted on October 1, 1993, and annually thereafter by a percentage equal to the lesser of:
      i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or
      ii) The percentage increase in the statewide average hospital payment rate, as described in subsection (k)~~(1)~~(8) of this Section, over the previous year's statewide average hospital payment rate.
   F) The amount calculated pursuant to subsection ~~subsections~~ (g)(1) ~~and--(g)(2)(B)-through-(g)(2)(E)~~ above for hospitals described in Section 148.25(b)(1)(A) shall be no less than the DSH rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.
   G) The amount calculated pursuant to subsections (g)(1) and (g)(2)(B) through (g)(2)(E) above, as adjusted pursuant to subsections (h)~~,~~ and (i)~~,--and--(j)~~ below, shall be the inpatient payment adjustment in dollars for the applicable DSH determination year, subject to the limitations described in subsections (g)(2)(D) and (j)~~(k)~~ of this Section, and the adjustment described in subsection (g)(2)(F) above. The adjustments calculated under subsections (g)(1) and (g)(2)(B) through (g)(2)(F) of this Section shall be paid on a per diem basis and shall be applied to each covered day of care provided.
3) DMHDD State-Operated Facility Adjustment for hospitals defined in Section 148.25(b)(6). Department of Mental Health and Developmental Disabilities (DMHDD) State-operated facilities qualifying under subsection (a)(2) shall receive an adjustment for inpatient services provided on or after March 1, 1995. The amount of that payment shall be calculated as follows:



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A) The amount of the adjustment is based on a State DSH Pool. The State DSH Pool amount shall be calculated by subtracting the estimated DSH payment adjustments made under subsection (g)(1) through (g)(2) above and Section ~~Sections 148.160(f)(2) and~~ 148.170(f)(2) from the aggregate DSH payment adjustment set by the Health Care Financing Administration (HCFA) in accordance with Public Law 102-234.

B) The State DSH Pool amount is then allocated to hospitals defined in Section 148.25(b)(6) that qualify for DSH adjustments by multiplying the State DSH Pool amount by each hospital's ratio of Medicaid inpatient utilization (adjusted based upon historical utilization and projected increases in utilization) to the sum of all qualifying hospitals' Medicaid inpatient utilization.

C) The adjustment calculated in (g)(3)(B) above shall meet the limitation described in subsection (j)~~(k)~~(4) below.

D) The adjustment calculated pursuant to subsection (g)(3)(B) above, for each hospital defined in Section 148.25(b)(6) that qualifies for DSH adjustments, is then divided by the Medicaid inpatient utilization data (adjusted based upon historical utilization and projected increases in utilization) to arrive at a per day adjustment. This amount is subject to the limitations described in subsection (j)~~(k)~~ of this Section. The adjustment described in this subsection shall be paid on a per diem basis and shall be applied to each Medicaid covered day of care provided.

h) Inpatient Adjuster for Children's Hospitals. For a children's hospital, as defined in subsection (a)(5) of this Section, the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 2.0.

~~i) Inpatient--Adjustor--County-Owned--Hospitals.----For--county-owned hospitals,-defined-in-Section-148.25(b)(1)(A),-the-payment--adjustment calculated-under-subsection-(g)(2)-above-shall-be-multiplied-by-3.75.~~

i)~~j)~~ Inpatient Adjustor for Hospitals Organized Under the University of Illinois Hospital Act. For a hospital and/or hospitals organized under the University of Illinois Hospital Act, as defined in Section 148.25(b)(1)(B), the payment adjustment calculated under subsection (g)(2) above shall be multiplied by 1.50.

j)~~k)~~ DSH Adjustment Limitations.

1) Hospitals that qualify for DSH adjustments under this Section shall not be eligible for the total DSH adjustment if, during the DSH determination year, the hospital discontinues the provision of non-emergency obstetrical care (the provisions of this subsection shall not apply to those hospitals described in 89 Ill. Adm. Code 149.50(c)(1) through (c)(4) or those hospitals that have not offered nonemergency obstetric services as of December 22, 1987). In this instance, the adjustments calculated under subsections (g)(1) and (g)(2) shall cease effective on the



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date that the hospital discontinued the provision of such non-emergency obstetrical care.

2) Inpatient Payment Adjustments based upon DSH Determination Reviews. Appeals based upon a hospital's ineligibility for DSH payment adjustments, or their payment adjustment amounts, in accordance with Section 148.310(b), which result in a change in a hospital's eligibility for DSH payment adjustments or a change in a hospital's payment adjustment amounts, shall not affect the DSH status of any other hospital or the payment adjustment amount of any other hospital that has received notification from the Department of their eligibility for DSH payment adjustments based upon the requirements of this Section.

3) DSH Payment Adjustment. In accordance with Public Law 102-234, if the aggregate DSH payment adjustments calculated under this Section do not meet the State's final DSH Allotment as determined by the Health Care Financing Administration (HCFA), DSH payment adjustments calculated under this Section shall be adjusted to meet the State DSH Allotment. This adjustment shall first be applied to DSH payments made under subsection (g)(3) above. If further adjustments are necessary, then DSH payments made under subsection (g)(2) above shall be adjusted, with the DSH payments under subsection (g)(1) being adjusted last.

4) Omnibus Budget Reconciliation Act of 1993 (OBRA'93) Adjustments. In accordance with Public Law 103-66, adjustments to individual hospitals' disproportionate share payments shall be made if the sum of Medicaid payments (inpatient, outpatient, and disproportionate share) made to a hospital exceed the costs of providing services to Medicaid clients and persons without insurance. The adjustments shall reduce disproportionate share spending until the costs and spending (described in the previous sentence) are equal or until the disproportionate share payments are reduced to zero. In this calculation, persons without insurance costs do not include contractual allowances. Hospitals qualifying for DSH payment adjustments must submit the information required in Section 148.150.

5) Medicaid Inpatient Utilization Rate Limit. Hospitals that qualify for DSH payment adjustments under this Section shall not be eligible for DSH payment adjustments if the hospital's Medicaid inpatient utilization rate, as defined in subsection (k)~~(k)~~(5) below, is less than one percent.

k)~~l)~~ Inpatient Payment Adjustment Definitions. The definitions of terms used with reference to calculation of the inpatient payment adjustments are as follows:

1) "Base fiscal year" means, for example, the hospital's fiscal year ending in 1991 for the October 1, 1993 DSH determination year, the hospital's fiscal year ending in 1992 for the October 1, 1994, DSH determination year, etc.

2) "DSH determination year" means the 12 month period beginning on

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October 1 of the year and ending September 30 of the following year.

3) "Mean Medicaid inpatient utilization rate" means a fraction, the numerator of which is the total number of inpatient days provided in a given 12-month period by all Medicaid-participating Illinois hospitals to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total number of inpatient days provided by those same hospitals. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in subsection (c)(3) of this Section. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.

4) "Mean Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the total Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (k)~~(1)~~(7) below, provided by all Medicaid-participating Illinois hospitals providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the Federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (k)~~(1)~~(9) below, for all such hospitals. That information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

5) "Medicaid inpatient utilization rate" means a fraction, the numerator of which is the number of a hospital's inpatient days provided in a given 12-month period to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a et seq.) and the denominator of which is the total number of the hospital's inpatient days in that same period. Title XIX specifically excludes days of care provided to Family and Children Assistance (formerly known as General Assistance) and Aid to the Medically Indigent (AMI) days but does include the types of days described in subsection (c)(3) of this Section. In this paragraph, the term "inpatient day" includes each day in which an individual (including a newborn) is an inpatient in the hospital whether or not the individual is in a specialized ward and whether or not the individual remains in the hospital for lack of suitable placement elsewhere.



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6) "Medicaid obstetrical inpatient utilization rate" means a fraction, the numerator of which is the Medicaid (Title XIX) obstetrical inpatient days, as defined in subsection (k)~~(1)~~(7) below, provided by a Medicaid-partcipating Illinois hospital providing obstetrical services to patients who, for such days, were eligible for Medicaid under Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396a et seq.), and the denominator of which is the total Medicaid (Title XIX) inpatient days, as defined in subsection (k)~~(1)~~(9) below provided by such hospital. This information shall be derived from claims for applicable services provided in the Medicaid obstetrical inpatient utilization rate base year which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base.

7) "Medicaid (Title XIX) obstetrical inpatient days" means hospital inpatient days which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

8) "Statewide average hospital payment rate" means the hospital's alternative reimbursement rate, as defined in Section 148.270(a).

9) "Total Medicaid (Title XIX) inpatient days", as referred to in subsections (k)~~(1)~~(4) and (k)~~(1)~~(6) above, means hospital inpatient days, excluding days for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the DSH determination year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, and specifically excludes Medicare/Medicaid crossover claims.

10) "Medicaid obstetrical inpatient utilization rate base year" means, for example, state fiscal year 1992 for the October 1, 1993, DSH determination year; state fiscal year 1993 for the October 1, 1994, DSH determination year, etc.

(Source: Amended at 19 Ill. Reg. 16630, effective NOV 28 1995)

**Section 148.140 Hospital Outpatient and Clinic Services**

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a) Fee-For-Service Reimbursement

1) Reimbursement for hospital outpatient hospital-based and clinic services shall be made on a fee for service basis, except for:

A) Those services that meet the definition of the Hospital Ambulatory Care Program as described in subsection (b) of this Section, which shall be reimbursed in accordance with subsections (b)(4) and (b)(6)~~(5)~~ of this Section, and adjusted in accordance with subsection (b)(8)~~(7)~~ of this Section;

B) ESRDT services, as described in subsection (c) of this Section, which shall be reimbursed in accordance with subsection (c) of this Section, and adjusted in accordance with subsection (c)(5) of this Section; and

C) Those services provided by a Certified Pediatric Ambulatory Care Center (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), which shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b).

2) Fee-for-service reimbursement levels shall be at the lower of the hospital's usual and customary charge to the public or the Department's statewide maximum reimbursement screens. Hospitals will be required to bill the Department utilizing specific service codes. However, all specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals in the same manner as to non-hospital providers who bill fee for service.

3) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rate described in subsection (a)(2) above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

A) The reimbursement rates described in subsection (a)(2) above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

4) Healthy Moms/Healthy Kids rates, as described in 89 Ill. Adm. Code 140 Table M, shall be paid to Certified Hospital Ambulatory Primary Care Centers (CHAPCC), as described in 89 Ill. Adm. Code 140.461(f)(1)(A) and Section 148.25(b)(5)(A), Certified Hospital Organized Satellite Clinics (CHOSC), as described in 89 Ill. Adm. Code 140.461(f)(1)(B) and Section 148.25(b)(5)(B), and Certified Obstetrical Ambulatory Care Centers (COBACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(C) and Section 148.25(b)(5)(C).



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Healthy Moms/Healthy Kids rates shall also be paid to Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), for covered services as described in 89 Ill. Adm. Code 140.462(e)(3), that are provided to non-assigned Healthy Moms/Healthy Kids program clients, as described in 89 Ill. Adm. Code 140.464(b)(1).

5) Certified Pediatric Ambulatory Care Centers (CPACC), as described in 89 Ill. Adm. Code 140.461(f)(1)(D) and Section 148.25(b)(5)(D), shall be reimbursed in accordance with 89 Ill. Adm. Code 140.464(b)(2) for assigned clients.

6) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B)~~,~~ shall be required to submit outpatient cost reports to the Department within 90 days after ~~of~~ the close of the facility's fiscal year.

7) With the exception of the retrospective adjustment described in subsection (a)(3) above, no year-end reconciliation is made to the reimbursement rates calculated under this Section.

b) Hospital Ambulatory Care Program

Effective April 1, 1986, the Department liberalized the list of allowable ambulatory procedures to add many surgical, diagnostic and highly technical treatment procedures that can be performed and reimbursed on an ambulatory basis.

1) Hospital Ambulatory Care Groupings

Under the Hospital Ambulatory Care Program, a Hospital Ambulatory Care list was developed that defines those technical procedures that require the use of the hospital outpatient or hospital-based clinic setting, its technical staff and/or equipment. These procedures were separated into four separate groupings based upon the complexity and historical costs of the procedures. The four separate groupings are as follows:

A) Group I procedures are high level technology surgeries that consume many hospital resources and are costly to deliver.

B) Group II procedures are certain nonsurgical, very high level technology services recognized and approved by the Department as safe outpatient procedures.

C) Group III procedures are other surgical, specialized cardiac and diagnostic procedures.

D) Group IV procedures are specialized treatment procedures, observation services, high risk, and emergency room services.

2) Hospital Ambulatory Care List Updating

The Hospital Ambulatory Care List is updated periodically. As technology changes, so do the procedures that fall into the four categories. In addition, annual changes in the ICD-9-CM procedure codes and their meanings necessitate annual changes to the Hospital Ambulatory Care List.

3) Hospital Ambulatory Care Reimbursement Prior to July 1, 1995

Reimbursement for Hospital Ambulatory Care procedures was

initially developed in 1986. For each of the four separate groupings identified in subsection (b)(1) above, a set rate maximum has been developed based upon the complexity of the procedures, historical costs, and teaching status of the hospital, the type of hospital, and the setting in which the procedure would most likely be performed (i.e., outpatient department, general clinic department, psychiatric clinic department, or rehabilitation clinic department). These set rate maximums have been periodically adjusted since 1986 based upon the above factors. Reimbursement for Hospital Ambulatory Care procedures performed prior to July 1, 1995, shall be reimbursed in accordance with the statutes and administrative rules governing the time period when the services were rendered.

4) Hospital Ambulatory Care Reimbursement Effective July 1, 1995
Effective July 1, 1995, reimbursement for Hospital Ambulatory Care procedures shall be as follows:

A) With respect to Group I procedures described in subsection (b)(1)(A) above, reimbursement shall be at the lesser of charges or the hospital's alternate reimbursement rate equivalent to the rate, as defined in Section 148.270(a), of a one-day inpatient stay.

B) With respect to Group II procedures described in subsection (b)(1)(B) above, reimbursement shall be at the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as:

i) A hospital defined in Section 148.25(b)(2)(A) through (b)(2)(C) which is a major teaching hospital as defined in Section 148.25(d); or a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3); or

ii) A hospital defined in Section 148.25(b).

C) With respect to the Group III procedures described in subsection (b)(1)(C) above, reimbursement shall be at the lesser of charges or one of two separate rate maximums depending upon whether the hospital is classified as:

i) A hospital defined in Section 148.25(b)(2)(A) through (b)(2)(C) which is a major teaching hospital, as defined in Section 148.25(d); or a children's hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3); or

ii) A hospital defined in Section 148.25(b).

D) With respect to the Group IV procedures described in subsection (b)(1)(D) above, reimbursement shall be at the lesser of charges or one of six separate rate maximums depending upon whether the hospital is classified as:

i) A hospital defined in Section 148.25(b)(2)(A) through (b)(2)(C) which is a major teaching hospital, as defined in Section 148.25(d); or a children's



hospital, as defined in 89 Ill. Adm. Code 149.50(c)(3); or

ii) A hospital defined in Section 148.25(b); and

iii) Whether the service is provided in the outpatient, general clinic, psychiatric clinic, or rehabilitation clinic department.

5) County Facility Outpatient Adjustment

A) Effective for services provided on or after July 1, 1995, county owned hospitals in an Illinois county with a population of over three million shall be eligible for a county facility outpatient adjustment payment. This adjustment payment shall be in addition to the amounts calculated under this Section and are calculated as follows:

i) For the rate year July 1, 1995, through June 30, 1996, hospitals under this subsection shall receive an annual adjustment payment equal to total base year hospital outpatient costs trended forward to the rate year minus total estimated rate year hospital outpatient payments, multiplied by the resulting ratio derived when the value 200 is divided by the quotient of the difference between total base year hospital outpatient costs trended forward to the rate year and total estimated rate year hospital outpatient payments divided by one million.

ii) The county facility outpatient adjustment under this subsection shall be made on a quarterly basis.

B) County Facility Outpatient Adjustment Definition. The definitions of terms used with reference to calculation of the county facility outpatient adjustment are as follows:

i) "Base Year" means the most recently completed State fiscal year.

ii) "Rate Year" means the State fiscal year during which the county facility adjustment payments are made.

iii) "Total Estimated Rate Year Hospital Outpatient Payments" means the Department's total estimated outpatient date of service liability, projected for the upcoming rate year.

iv) "Total Hospital Outpatient Costs" means the statewide sum of all hospital outpatient costs derived by summing each hospital's outpatient charges derived from actual paid claims data multiplied by the hospital's cost-to-charge ratio.

6)~~5~~ No Year-End Reconciliation
With the exception of the retrospective rate adjustment described in subsection (b)(7)~~6~~ of this Section, no year-end reconciliation is made to the reimbursement rates calculated under subsection (b).

7)~~6~~ Rate Adjustments

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With respect to those hospitals described in Sections 148.25(b)(2)(A), the reimbursement rates described in subsection (b)(4) above shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

A) The reimbursement rates described in subsection (b)(4) above shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

8)~~7)~~ Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies (relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to hospitals reimbursed under the Ambulatory Care Program in the same manner as to encounter rate hospitals and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.

9)~~8)~~ Hospitals described in Sections 148.25(b)(2)(A) and (b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close after the facility's fiscal year.

c) Payment for outpatient end-stage renal disease treatment (ESRDT) services provided pursuant to Section 148.40(c) shall be made at the Department's payment rates, as follows:

1) For inpatient hospital services provided pursuant to Section 148.40(c)(1), the Department shall reimburse hospitals pursuant to Sections 148.240 through 148.300 and 89 Ill. Adm. Code 149.

2) For outpatient services or home dialysis treatments provided pursuant to Sections 148.40(c)(2) or 148.40(c)(3), the Department will reimburse hospitals and clinics for ESRDT services at a rate which will reimburse the provider for the dialysis treatment and all related supplies and equipment, as defined in 42 CFR 405.2163 (1994). This rate will be that rate established by Medicare pursuant to 42 CFR 405.2124 and 405.2130 (1994).

3) Payment for non-routine services. For services which are provided during outpatient or home dialysis treatment pursuant to Sections 148.40(c)(2) or 148.40(c)(3) but are not defined as a routine service under 42 CFR 405.2163 (1994), separate payment will be made to independent laboratories, pharmacies, and medical supply providers pursuant to 89 Ill. Adm. Code 140.430 through 140.434, 140.440 through 140.450, and 140.475 through 140.481, respectively.



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4) Payment for physician services relating to ESRDT will be made separately to physicians, pursuant to 89 Ill. Adm. Code 140.400.

5) With respect to those hospitals described in Section 148.25(b)(2)(A), the reimbursement rates described in this subsection (c) shall be adjusted on a retrospective basis. The retrospective adjustment shall be calculated as follows:

A) The reimbursement rates described in this subsection (c) shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports.

B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

6) With the exception of the retrospective rate adjustment described in subsection (c)(5) above, no year-end reconciliation is made to the reimbursement rates calculated under this subsection (c).

7) Hospitals described in Sections 148.25(b)(2)(A) and 148.25(b)(2)(B) shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year.

d) Non Hospital Based Clinic Reimbursement

1) County-Operated Outpatient Facility Reimbursement

Reimbursement for all services provided by county-operated outpatient facilities, as described in Section 148.25(b)(2)(C), that do not qualify as Healthy Moms/Healthy Kids Managed Care clinics, as described in 89 Ill. Adm. Code 140.46(f), shall be on an all-inclusive per encounter rate basis as follows:

A) Base Rate. The per encounter base rate shall be calculated as follows:

i) Allowable direct costs shall be divided by the number of direct encounters to determine an allowable cost per encounter delivered by direct staff.

ii) The resulting quotient, as calculated in subsection (d)(1)(A)(i) above, shall be multiplied by the Medicare allowable overhead rate factor to calculate the overhead cost per encounter.

iii) The resulting product, as calculated in subsection (d)(1)(A)(ii) above, shall be added to the resulting quotient, as calculated in subsection (d)(1)(A)(i) above to determine the per encounter base rate.

iv) The resulting sum, as calculated in subsection (d)(1)(A)(iii) above, shall be the per encounter base rate.

B) Supplemental Rate

i) The supplemental service cost shall be divided by the

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total number of direct staff encounters to determine the direct supplemental service cost per encounter.

ii) The supplemental service cost shall be multiplied by the allowable overhead rate factor to calculate the supplemental overhead cost per encounter.

iii) The quotient derived in subsection (d)(1)(B)(i) above, shall be added to the product derived in subsection (d)(1)(B)(ii) above, to determine the per encounter supplemental rate.

iv) The resulting sum, as described in subsection (d)(1)(B)(iii) above, shall be the per encounter supplemental rate.

C) Final Rate

i) The per encounter base rate, as described in subsection (d)(1)(A)(iv), shall be added to the per encounter supplemental rate, as described in (d)(1)(B)(iv), to determine the per encounter final rate.

ii) The resulting sum, as determined in subsection (d)(1)(C)(i) above, shall be the per encounter final rate.

iii) The per encounter final rate, as described in subsection (d)(1)(C)(ii) above, shall be adjusted in accordance with subsection (d)(2) below.

2) Rate Adjustments

Rate adjustments to the per encounter final rate, as described in subsection (d)(1)(C)(iii) above, shall be calculated as follows:

A) The reimbursement rates described in subsections (d)(1)(A) through (d)(1)(C) of this Section shall be no less than the reimbursement rates in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

B) The per diem cost of inpatient hospital services shall be calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

3) County-operated outpatient facilities, as described in Section 148.25(b)(2)(C), shall be required to submit outpatient cost reports to the Department within 90 days after the close of the facility's fiscal year. No year-end reconciliation is made to the reimbursement calculated under this subsection (d).

4) Services are available to all clients in geographic areas in which an encounter rate hospital or a county-operated outpatient facility is located. All specific client coverage policies



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(relating to client eligibility and scope of services available to those clients) which pertain to the service billed are applicable to encounter rate hospitals in the same manner as to hospitals reimbursed under the Ambulatory Care Program and to non-hospital and hospital providers who bill and receive reimbursement on a fee-for-service basis.

(Source: Amended at 19 Ill. Reg. 16630, effective NOV 28 1995)

**Section 148.160 Payment Methodology for County-Owned Hospitals in an Illinois County with a Population of Over Three Million**

a) Reimbursement Methodology

In accordance with 89 Ill. Adm. Code 149.50(c)(8), county-owned hospitals in an Illinois county with a population greater than three million are excluded from the DRG PPS and are reimbursed in accordance with this Section.

b) Base Year Costs

1) The hospitals' base year operating costs shall be contained in the hospitals' audited cost reports (see 42 CFR 447.260 and 447.265 (1982)) for hospital fiscal years ending between 20 and 31 months prior to the fiscal year for which rates are being set.

2) The hospitals' base year capital related costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) above.

3) The hospitals' base year direct medical education costs shall be derived from the same audited cost reports used for operating costs in subsection (b)(1) above.

4) The base year cost per diem shall be the sum of the operating cost per diem, capital related cost per diem and medical education cost per diem defined in subsections (b)(1) through (b)(3).

5) New hospitals, for which a base year cost report is not on file, will be reimbursed the per diem rate calculated in subsection (b)(4) above and inflated in subsection (d)(1) below.

c) Restructuring Adjustment

Adjustments to the base year cost per diem, as described in subsection (b)(4) above, will be made to reflect restructuring since filing the base year cost reports. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost reports available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited

cost reports to determine restructuring costs. If audited cost reports become available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Office of Health Finance, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited reports received at the Finance Section between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the reports are received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies, and added to the base year cost per diem, as described in subsection (b)(4), which is subject to the inflation adjustment described in subsection (d) below.

d) Inflation Adjustment For Base Year Cost Report Inflator

1) The base year cost per diem, as defined in subsection (b)(4) above, shall be inflated from the midpoint of the hospitals' base year to the midpoint of the time period for which rates are being set (rate period) according to the historical rate of annual cost increases. The historical rate of annual cost increases shall be calculated by dividing the operating cost per diem as defined in subsection (b)(1) above by the previous year's operating cost per diem.

2) Effective October 1, 1992, the final reimbursement rate shall be no less than the reimbursement rate in effect on June 1, 1992; except that this minimum shall be adjusted each July 1 thereafter by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports.

e) Review Procedure

The review procedure shall be in accordance with Section 148.310.

f) Applicable Inpatient Adjustments ~~for DSH Hospitals~~

1) The criteria and methodology for making applicable adjustments to DSH hospitals which are exempt from the DRG PPS, as described in subsection (a) above, shall be in accordance with Section 148.120.

2) The criteria and methodology for making applicable Medicaid Percentage Adjustments to hospitals which are exempt from the DRG PPS as described in subsection (a) above is described below.

A) The payment adjustment shall be $150 plus $2 for each one percent that the hospital's Medicaid inpatient utilization rate as described in Section 148.120(k)(5), exceeds 1.5 standard deviations above the mean Medicaid inpatient utilization rate as defined in Section 148.120(k)(3) multiplied by 3.75. This payment adjustment is based on a



rate year 1993 base rate and shall be trended forward to the current rate year for inflationary increases.

B) The amount calculated pursuant to subsection (f)(2)(A) above shall be adjusted on October 1, 1995, and annually thereafter, by a percentage equal to the lesser of:

i) The increase in the national hospital market basket price proxies (DRI) hospital cost index for the most recent 12 month period for which data are available; or

ii) The percentage increase in the statewide average hospital payment rate, as described in Section 148.120(k)(8) over the previous year's statewide average hospital payment rate.

C) The amount calculated pursuant to subsections (f)(2)(A) through (f)(2)(B) above shall be no less than the rate calculated in accordance with Section 148.120(g)(2) in effect on June 1, 1992, except that this minimum shall be adjusted on the first day of July of each year by the annual percentage change in the per diem cost of inpatient hospital services as reported on the two most recent Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid costs by the total allowable Medicaid days.

D) The amount calculated pursuant to subsection (f)(2) above shall be the Medicaid percentage adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

3) Critical Inpatient Adjustment.

A) Effective July 1, 1995, hospitals reimbursed under this Section shall be eligible to receive a critical inpatient adjustment. The methodology used to determine the add-on payment amount is as follows:

i) For the rate year July 1, 1995, through June 30, 1996, hospitals under this Section shall receive $15,500 per Medicaid inpatient admission in the base period.

ii) The payments made under this subsection shall be made on a quarterly basis.

B) Critical Inpatient Adjustment Definitions.

i) "Base Period" means State fiscal year 1994 for critical inpatient adjustments calculated and paid during State fiscal year 1996.

ii) "Medicaid Inpatient Admission" means hospital inpatient admissions, which were subsequently adjudicated by the Department through the last day of June preceding the rate year and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns

and Medicare/Medicaid crossover days.

4)~~2)~~ Hospitals ~~in addition to the BSH payment adjustment described in Section 148.120, hospitals~~ reimbursed under this Section shall receive supplemental inpatient BSH payments. Effective with admissions on or after July 1, 1995, ~~October 1, 1993,~~ supplemental inpatient BSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the base year cost per diem, as described in subsection (b)(4) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for inflation, as described in subsection (d) above, and the sum of the calculated disproportionate share and Medicaid percentage per diem payments ~~payment adjustment~~ as described in Section 148.120 and subsection (f)(2) above, by the hospitals' percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. Effective July 1, 1995, ~~October 1, 1992,~~ the supplemental inpatient BSH payments calculated under this subsection shall be no less than the supplemental inpatient BSH rates in effect on June 1, 1992, except that this minimum shall be adjusted as of July 1, 1992, and on the first day of July of each year thereafter, by the annual percentage change in the per diem cost of inpatient hospital services as reported in the most recent annual Medicaid cost reports. The per diem cost of inpatient hospital services is calculated by dividing the total allowable Medicaid cost by the total allowable Medicaid days. The supplemental inpatient BSH payment adjustment shall be paid on a per diem basis and shall be applied to each covered day of care provided.

g) Outlier Adjustments
Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.

h) Trauma Center Adjustments. Trauma center adjustments shall be made in accordance with Section 148.290(c).

i) Reductions to Total Payments
1) Copayments. Copayments are assessed under all medical programs administered by the Department except the Family and Children Assistance Program, formerly known as the General Assistance Program, and shall be assessed in accordance with Section 148.190.
2) Third Party Payments. The requirements of Section 148.290(f)(2) shall apply.

j) Prepayment and Utilization Review
Prepayment and utilization review requirements shall be in accordance with Section 148.240.

k) Cost Reporting Requirements
Cost reporting requirements shall be in accordance with Section 148.210.



~~l)~~ ~~Rate Period~~
~~The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year.~~

(Source: Amended at 19 Ill. Reg. 16630, effective NOV 28 1995)

**Section 148.170 Payment Methodology for Hospitals Organized Under the University of Illinois Hospital Act**

a) In accordance with 89 Ill. Adm. Code 149.50(c)(8), a hospital organized under the University of Illinois Hospital Act shall be excluded from the DRG PPS and shall be reimbursed in accordance with this Section.

b) Base Year Costs
1) Each hospital's base year cost per diem shall be derived from an audited cost report (see 42 CFR 447.260 and 447.265 (1982)) for hospitals' fiscal year 1992.
2) For new hospitals for which a base year cost report is not on file, the Department will use a more recent filed cost report or, if no cost report is on file, the hospital's estimate of costs, adjusted as necessary according to experience with hospitals of similar size, location and service intensity. The Department will recalculate any reimbursement rate based on a rate estimated as soon as a cost report becomes available. The recalculated rate will be effective for the entire fiscal year and the Department will retroactively adjust payments if reported costs are not consistent with the estimate on which the payments are based.

c) Restructuring Adjustment
Adjustments to base year costs will be made to reflect restructuring since filing the base year cost report. The restructuring must have been mandated to meet state, federal or local health and safety standards. The allowable Medicare/Medicaid costs (see 42 CFR Part 405, Subpart D, 1982) must be incurred as a result of mandated restructuring and identified from the most recent audited cost report available before or during the rate year. The restructuring costs must be significant, i.e., on a per unit basis; they must constitute one percent or more of the total allowable Medicare/Medicaid unit costs for the same time period. The Department will use the most recent available audited cost report to determine restructuring costs. If an audited cost report becomes available during the rate year, the reimbursement rate will be recalculated at that time to reflect restructuring cost adjustments. For audited reports received at the Finance Section, Illinois Department of Public Aid, between the first and fifteenth of the month, the effective date of the recalculated rate will be the first day of the following month. For audited

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reports received at the Office of Health Finance between the sixteenth and last day of the month, the effective date will be the first day of the second month following the month the report is received. Allowable restructuring costs are adjusted to account for inflation from the midpoint of the restructuring cost reporting year to the midpoint of the base year according to the index and methodology of Data Resources, Inc. (DRI), national hospital market basket price proxies and added to the base year costs.

d) Inflation Adjustment For Base Year Cost Report Inflator
Base year costs, including any adjustments for mandated restructuring, will be updated from the midpoint of each hospital's base year to the midpoint of the fiscal year for which rates are being set according to the hospital's historical rate of annual cost increases.

e) Review Procedure
The review procedure shall be in accordance with Section 148.310.

f) Applicable adjustments for DSH Hospitals
1) The criteria and methodology for making applicable adjustments to DSH hospitals which are exempt from the DRG PPS as described in subsection (a) above, shall be in accordance with Section 148.120.
2) Effective October 1, 1993, in addition to the DSH payment adjustments described in Section 148.120, hospitals reimbursed under this Section shall have supplemental DSH payments effective with admissions on or after October 1, 1993, supplemental DSH payments for hospitals reimbursed under this Section shall be calculated by multiplying the sum of the hospital's base year costs, as described in subsection (b) above, as adjusted for restructuring, as described in subsection (c) above, and as adjusted for inflation, as described in subsection (d) above, and the calculated disproportionate share per diem payment adjustment as described in Section 148.120 by the hospital's percentage of charges which are not reimbursed by a third party payer for the period of August 1, 1991, through July 31, 1992. The resulting product shall be multiplied by 4.50 ~~1.50~~ and this amount shall be the supplemental DSH payment adjustment which shall be paid on a per diem basis and shall be applied to each covered day of care provided.

g) Outlier Adjustments
Outlier adjustments to payment amounts for medically necessary inpatient hospital services involving exceptionally high costs for certain individuals shall be made in accordance with Section 148.130.

h) Reductions to Total Payments
1) Copayments. Copayments are assessed under all medical programs administered by the Department except the Children and Family Assistance Program, formerly known as the General Assistance Program, and shall be assessed in accordance with Section 148.190.
2) Third Party Payments. The requirements of Section 148.290(f)(2)



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shall apply.

i) Prepayment and Utilization Review
Prepayment and utilization review requirements shall be in accordance with Section 148.240.

j) Cost Reporting Requirements
Cost reporting requirements shall be in accordance with Section 148.210.

k) Rate Period
The rate period for hospitals reimbursed under this Section shall be the 12 month period beginning on October 1 of the year and ending September 30 of the following year, except for the period of July 1, 1995, through September 30, 1995.

(Source: Amended at 19 Ill. Reg. 16630, effective NOV 28 1995)

**Section 148.295 Critical Hospital Adjustment Payments (CHAP)**

Critical Hospital Adjustment Payments (CHAP) shall be made to all eligible hospitals excluding county-owned hospitals, as described in Section 148.25 (b)(1)(A), and hospitals organized under the University of Illinois Hospital Act, as described in Section 148.25 (b)(1)(B), for inpatient admissions occurring on or after July 1, 1995, in accordance with this Section.

a) Trauma Center Adjustments (TCA)
The Department shall make a trauma center adjustment (TCA) to Illinois hospitals recognized, as of the last day of June preceding the CHAP rate period, as a Level I or Level II trauma center by the Illinois Department of Public Health, in accordance with the provisions of subsections (a)(1) through (a)(3) below.

1) Level I Trauma Center Adjustment (TCA).

A) Criteria. Illinois hospitals that, on the last day of June preceding the CHAP rate period, are recognized as a Level I trauma center by the Illinois Department of Public Health shall receive the Level I trauma center adjustment.

B) Adjustment. Illinois hospitals meeting the criteria specified in subsection (a)(1)(A) above shall receive an adjustment as follows:

i) Hospitals with Medicaid trauma admissions equal to or greater than the mean Medicaid trauma admissions, for all hospitals qualifying under (a)(1)(A) above, shall receive an adjustment of $19,200.00 per Medicaid trauma admission in the CHAP base period.

ii) Hospitals with Medicaid trauma admissions less than the mean Medicaid trauma admissions, for all hospitals qualifying under (a)(1)(A) above, shall receive an adjustment of $12,000.00 per Medicaid trauma admission in the CHAP base period.

2) Level II Rural Trauma Center Adjustment (TCA). Illinois rural

hospitals, as defined in Section 148.25(g)(3), that, on the last day of June preceding the CHAP rate period, are recognized as a Level II trauma center by the Illinois Department of Public Health shall receive an adjustment of $9,400.00 per Medicaid trauma admission in the CHAP base period.

3) Level II Urban Trauma Center Adjustment (TCA). Illinois urban hospitals, as described in Section 148.25(g)(4), that, on the last day of June preceding the CHAP rate period, are recognized as Level II trauma centers by the Illinois Department of Public Health shall receive an adjustment of $9,400.00 per Medicaid trauma admission in the CHAP base period, provided that such hospital meets the criteria described below:

A) The hospital is located in a county with no Level I trauma center; and

B) The hospital is located in a Health Professional Shortage Area (HPSA) (42 CFR 5), as of the last day of June preceding the CHAP rate period, and has a Medicaid trauma admission percentage at or above the mean of the individual facility values determined in subsection (a)(3)(A) above; or the hospital is not located in a HPSA (42 CFR 5) and has a Medicaid trauma admission percentage that is at least the mean plus one standard deviation of the individual facility values determined in subsection (a)(3)(A) above.

b) Rehabilitation Hospital Adjustment (RHA)

Illinois hospitals that, on the last day of June preceding the CHAP rate period, qualify as rehabilitation hospitals, as defined in 89 Ill. Adm. Code 149.50(c)(2) and are accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF), shall receive a rehabilitation hospital adjustment in the CHAP rate period that consists of the following three components:

1) Treatment Component. All hospitals defined in subsection (b) above shall receive $3,800.00 per Medicaid Level I rehabilitation admission in the CHAP base period.

2) Facility Component. All hospitals defined in subsection (b) above shall receive a facility component that shall be based upon the number of Medicaid Level I rehabilitation admissions in the CHAP base period as follows:

A) Hospitals with fewer than 100 Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $100,000.00 in the CHAP rate period.

B) Hospitals with 100 or more Medicaid Level I rehabilitation admissions in the CHAP base period shall receive a facility component of $400,000.00 in the CHAP rate period.

3) Health Professional Shortage Area Adjustment Component. Hospitals defined in subsection (b) above, that are located in a Health Professional Shortage Area (HPSA) (42 CFR 5) as of the last day of June preceding the CHAP rate period, shall receive



$300.00 per Medicaid Level I rehabilitation inpatient day in the CHAP base period.

c) Direct Hospital Adjustment (DHA) Criteria

To qualify for the DHA under this subsection (c), hospitals must meet one of the following criteria.

1) Be an Illinois hospital located outside of Health Service Area (HSA) six that meets one of the following criteria:

A) Has a Medicaid inpatient utilization rate on the last day of June preceding the CHAP rate period, as defined in Section 148.120(k)(5), greater than 60 percent and has an average length of stay of less than ten days.

B) Is a major teaching hospital with 35 or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

2) Be a hospital located in HSA six, excluding psychiatric and rehabilitation hospitals as defined in 89 Ill. Adm. Code 149.50(c)(1) and (c)(2), that meets one of the following criteria:

A) Is a hospital whose sum of the critical weighting factors is greater than one standard deviation above the mean of the summed critical weighting factors for all hospitals located within the same planning area. The critical weighting factor is determined as follows:

i) Hospitals that, on the last day of June preceding the CHAP rate period, are designated as a Level III, II, or I Perinatal Center by the Illinois Department of Public Health shall receive a critical weighting factor of 10, 7.5, or 5 respectively depending on the hospital's perinatal level designation.

ii) Hospitals that, on the last day of June preceding the CHAP rate period, are recognized as a Level I or II Trauma Center by the Illinois Department of Public Health shall receive a critical weighting factor of ten or five respectively depending on the hospital's trauma level designation.

iii) Hospitals that, on the last day of June preceding the CHAP rate period, are eligible for disproportionate share payments as described in Section 148.120(g)(1) or (g)(2) shall receive a critical weighting factor of five.

iv) Hospitals that have an occupancy ratio, as determined by the Illinois Department of Public Health (IDPH), based upon the most current IDPH published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal

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Hospitals in Illinois", which is available to the Illinois Department of Public Aid on the last day of June preceding the CHAP rate period, which is equal to or greater than the mean occupancy ratio for all hospitals in the planning area shall receive a critical weighting factor of five.

v) Hospitals which have Medicaid obstetrical care admissions in the CHAP base period that are equal to or greater than one-half a standard deviation above the mean Medicaid obstetrical care admissions in their planning area shall receive a critical weighting factor of ten. If the hospital's Medicaid obstetrical care admissions are greater than the mean but less than one-half a standard deviation above the mean Medicaid obstetrical care admissions in their planning area, the hospital shall receive a critical weighting factor of five.

vi) Hospitals that on the last day of June preceding the CHAP rate period have a Medicaid inpatient utilization rate as defined in Section 148.120(k)(5) which is equal to or greater than one-half a standard deviation above the mean Medicaid inpatient utilization rate in their planning area, shall receive a critical weighting factor of ten. If the hospital's Medicaid inpatient utilization rate is greater than the mean but less than one-half a standard deviation above the mean Medicaid inpatient utilization rate in their planning area, the hospital shall receive a critical weighting factor of five.

vii) Hospitals which have Medicaid general care admissions in the CHAP base period that are equal to or greater than one-half a standard deviation above the mean Medicaid general care admissions in their planning area shall receive a critical weighting factor of ten. If the hospital's Medicaid general care admissions are greater than the mean but less than one-half a standard deviation above the mean Medicaid general care admissions in their planning area, the hospital shall receive a critical weighting factor of five.

viii) Hospitals which have a cost per day at 80 percent occupancy that is less than or equal to one-half a standard deviation below the mean cost per day at 80 percent occupancy in their planning area shall receive a critical weighting factor of ten. If the hospital's cost per day at 80 percent occupancy is greater than one-half a standard deviation below the mean cost per day at 80 percent occupancy but less than the mean cost per day at 80 percent occupancy in their planning



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area, the hospital shall receive a critical weighting factor of five.

B) Is a major teaching hospital with 40 or more graduate medical education programs accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

C) Is a hospital with 3,400 or more Medicaid general care admissions in the CHAP base period.

3) Be a hospital qualifying under subsection (c)(2) above that has Medicaid obstetrical care admissions in the CHAP base period which are equal to or greater than 2,400.

4) Be a hospital qualifying under subsection (c)(2) above that on the last day of June preceding the CHAP rate period, is designated as a Level III or II Perinatal Center by the Illinois Department of Public Health, and that has a Medicaid inpatient utilization rate, as defined in Section 148.120(k)(5), which is greater than one-half a standard deviation above the statewide mean Medicaid inpatient utilization rate, as defined in Section 148.120(k)(3), and that has at least one obstetrical graduate medical education program accredited by the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation.

5) Be a children's hospital, which means a hospital devoted exclusively to caring for children. A hospital which includes a facility devoted exclusively to caring for children that is separately licensed as a hospital by a municipality shall be considered a children's hospital to the degree that the hospital's Medicaid care is provided to children.

d) DHA Adjustment

Calculation of the DHA is as follows:

1) Hospitals qualifying under subsection (c)(1)(A) above shall receive an DHA of $60.00 per Medicaid inpatient day in the CHAP base period.

2) Hospitals qualifying under subsection (c)(1)(B), (c)(2) or (c)(5) above shall receive an DHA of $30.00 per Medicaid inpatient day in the CHAP base period.

3) Hospitals qualifying under subsection (c)(5) above which have a Medicaid inpatient utilization rate, as defined in Section 148.120(k)(5), on the last day of June preceding the CHAP rate period, that is greater than 85 percent shall receive an additional $20.00 per Medicaid inpatient day in the CHAP base period.

4) Hospitals qualifying under subsection (c)(2)(B) above shall receive an additional $10.00 per Medicaid inpatient day in the

CHAP base period.

5) Hospitals qualifying under subsection (c)(3) or (c)(4) above shall receive an additional $120.00 per Medicaid inpatient day in the CHAP base period if their Medicaid inpatient utilization rate, as defined in Section 148.120(k)(5), on the last day of June preceding the CHAP rate period, is equal to or greater than 50 percent; or $65.00 per Medicaid inpatient day in the CHAP base period if their Medicaid inpatient utilization rate, as defined in Section 148.120(k)(5), on the last day of June preceding the CHAP rate period, is less than 50 percent.

e) Each eligible hospital's critical hospital adjustment payment for the CHAP rate period shall equal the sum of the amounts described in subsections (a), (b), and (d) above. The critical hospital adjustment payments shall be paid to eligible hospitals on a quarterly basis.

f) Critical Hospital Adjustment Limitations

Hospitals that qualify for trauma center adjustments under subsection (a) shall not be eligible for the total trauma center adjustment if, during the CHAP rate period, the hospital is no longer recognized by the Illinois Department of Public Health as a Level I trauma center as required for the adjustment described in subsection (a)(1) above, or a Level II trauma center as required for the adjustment described in subsection (a)(2) or (a)(3) above. In these instances, the adjustments calculated shall be pro-rated, as applicable, based upon the date that such recognition ceased.

g) Critical Hospital Adjustment Payment Definitions

The definitions of terms used with reference to calculation of the CHAP required by this Section are as follows:

1) "CHAP base period" means State Fiscal Year 1994 for CHAP payments calculated for the July 1, 1995, CHAP rate period; State Fiscal Year 1995 for CHAP payments calculated for the July 1, 1996, CHAP rate period; etc.

2) "CHAP rate period" means, beginning July 1, 1995, the 12 month period beginning on July 1 of the year and ending June 30 of the following year.

3) "Cost Per Day at 80 Percent Occupancy" means the estimated inpatient cost per day had the hospital been operating at an 80 percent occupancy rate.

4) "Medicaid General Care Admission" means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding admissions for normal newborns, Medicare/Medicaid crossover admissions, psychiatric and rehabilitation admissions.

5) "Medicaid Inpatient Day" means hospital inpatient days which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of the Social Security Act, excluding days for normal newborns and Medicare/Medicaid crossover days.

6) "Medicaid Level I rehabilitation admissions" means those claims billed as Level I admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an occurrence code of 63 when applicable and an ICD-9-CM principal diagnosis code of: 054.3, 310.1 through 310.2, 320.1, 336.0 through 336.9, 344.0 through 344.2, 344.8 through 344.9, 348.1, 801.30, 803.10, 803.84, 806.0 through 806.19, 806.20 through 806.24, 806.26, 806.29 through 806.34, 806.36, 806.4 through 806.5, 851.06, 851.80, 853.05, 854.0 through 854.04, 854.06, 854.1 through 854.14, 854.16, 854.19, 905.0, 907.0, 907.2, 952.0 through 952.09, 952.10 through 952.16, 952.2, and V57.0 through V57.89, excluding admissions for normal newborns.

7) "Medicaid Level I rehabilitation inpatient day" means the days associated with the claims defined in subsection (e)(6) above.

8) "Medicaid obstetrical care admission" means hospital inpatient admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, for recipients of medical assistance under Title XIX of Social Security Act, with an ICD-9-CM principal diagnosis code of 640.0 through 648.9 with a 5th digit of 1 or 2; 650; 651.0 through 659.9 with a 5th digit of 1, 2, 3, or 4; 660.0 through 669.9 with a 5th digit of 1, 2, 3, or 4; 670.0 through 676.9 with a 5th digit of 1 or 2; or V27 through V27.9; or V30 through V39.9; or any ICD-9-CM principal diagnosis code that is accompanied with a surgery procedure code between 72 and 75.99; and specifically excludes Medicare/Medicaid crossover claims.

9) "Medicaid trauma admission" means those claims billed as admissions which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with an ICD-9-CM principal diagnosis code of: 800.0 through 800.99, 801.0 through 801.99, 802.0 through 802.99, 803.0 through 803.99, 804.0 through 804.99, 805.0 through 805.98, 806.0 through 806.99, 807.0 through 807.69, 808.0 through 808.9, 809.0 through 809.1, 828.0 through 828.1, 839.0 through 839.3, 839.7 through 839.9, 850.0 through 850.9, 851.0 through 851.99, 852.0 through 852.59, 853.0 through 853.19, 854.0 through 854.19, 860.0 through 860.5, 861.0 through 861.32, 862.8, 863.0 through 863.99, 864.0 through 864.19, 865.0 through 865.19, 866.0 through 866.13, 867.0 through 867.9, 868.0 through 868.19, 869.0 through 869.1, 887.0 through 887.7, 896.0 through 896.3, 897.0 through 897.7, 900.0 through 900.9, 902.0 through 904.9, 925, 926.8, 929.0 through 929.99,

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958.4, 958.5, 990 through 994.99. For those hospitals recognized as Level I trauma centers solely for pediatric trauma cases, Medicaid trauma admissions are only calculated for the claims billed as admissions, excluding admissions for normal newborns, which were subsequently adjudicated by the Department through the last day of June preceding the CHAP rate period and contained within the Department's paid claims data base, with ICD-9-CM diagnoses within the above ranges for children under the age of 18 excluding admissions for normal newborns.

10) "Medicaid trauma admission percentage" means a fraction, the numerator of which is the hospital's Medicaid trauma admissions and the denominator of which is the total Medicaid trauma admissions in a given 12 month period for all Level II urban trauma centers.

(Source: Added at 19 Ill. Reg. 16630, effective NOV 28 1995)

**Section 148.310 Review Procedure**

a) Inpatient Rate Reviews

1) Hospitals shall be notified of their inpatient rate for the rate year and shall have an opportunity to request a review of the rate for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of their rates. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) Hospitals reimbursed in accordance with Sections 148.250 through 148.300 and 89 Ill. Adm. Code 149 with respect to per diem add-ons for capital may request that an adjustment be made to their base year costs to reflect significant changes in costs which have been mandated in order to meet State, federal or local health and safety standards, and which have occurred since the hospital's filing of the base year cost report. The allowable Medicare/Medicaid costs must be identified from the most recent audited cost report available. These costs must be significant, i.e., on a per unit basis, they must constitute one percent or more of the total allowable Medicaid/Medicare unit costs for the same time period. Appeals for base year cost adjustments must be received, in writing, by the Department within 30 days after the date of the Department's notice to the hospital of their rates. Such request shall include a clear explanation of the cost change and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

b) DSH Determination Reviews



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1) Hospitals shall be notified of their qualification for DSH payment adjustments and shall have an opportunity to request a review of the DSH add-on for errors in calculation. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of its disproportionate share qualification and add-on calculations. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) DSH determination reviews shall be limited to the following:

A) DSH Determination Criteria. The criteria for DSH determination shall be in accordance with Section 148.120. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.

B) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)~~(i)~~(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

C) Low Income Utilization Rates. Low Income utilization rates shall be calculated in accordance with Section 1923 of the Social Security Act and Section 148.120(a)(2) and (d). Review shall be limited to verification that low income utilization rates were calculated in accordance with federal and State regulations.

D) Federally Designated Health Manpower Shortage Areas (HMSAs). Illinois hospitals located in federally designated HMSAs shall be identified in accordance with 42 CFR 5, (1989), and Section 148.120(a)(3) based upon the methodologies utilized by, and the most current information available to the Department from the Department of Health and Human Services as of June 30, 1992. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HMSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HMSA as of June 30, 1992.

E) Excess Beds. Excess bed information shall be determined in accordance with Public Act 86-268 Code Section 148.120(a)(3) and 77 Ill. Adm. Code 1100) based upon the methodologies utilized by, and the most current information available to, the Illinois Health Facilities Planning Board as of July 1, 1991. Reviews shall be limited to requests accompanied by documentation from the Illinois Health Facilities Planning Board substantiating that the information supplied to and

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utilized by the Department was incorrect.

F) Medicaid Obstetrical Inpatient Utilization Rates. Medicaid obstetrical inpatient utilization rates shall be calculated in accordance with Section 148.120(a)(4), (k)~~(l)~~(4), (k)~~(l)~~(6) and (k)~~(l)~~(7). Review shall be limited to verification that Medicaid obstetrical inpatient utilization rates were calculated in accordance with State regulations.

c) Outlier Adjustment Reviews

The Department shall make outlier adjustments to payment amounts in accordance with 89 Ill. Adm. Code 149.105 or Section 148.130, whichever is applicable. Hospitals shall be notified of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment and shall have an opportunity to request a review of such specific information for errors in calculation only. Such a request must be received in writing by the Department within 30 days after the date of the Department's notice to the hospital of the specific information which shall be utilized in the determination of those services qualified for an outlier adjustment. Such request shall include a clear explanation of the error and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

d) Cost Report Reviews

1) Cost reports are required from:

A) All enrolled hospitals within the State of Illinois;

B) All out-of-state hospitals providing 100 inpatient days of service per hospital fiscal year, to persons covered by the Illinois Medical Assistance Program; and

C) All hospitals not located in Illinois that elect to be reimbursed under the methodology described in 89 Ill. Adm. Code 149 (the DRG PPS).

2) The completed cost statement with a copy of the hospital's Medicare cost report and audited financial statement must be submitted annually within 90 days of the close of the hospital's fiscal year. A one-time 30-day extension may be requested. Such a request for an extension shall be in writing and shall be received by the Department's Office of Health Finance prior to the end of the 90-day filing period. The Office of Health Finance shall audit the information shown on the Hospital Statement of Reimbursable Cost and Support Schedules. The audit shall be made in accordance with generally accepted auditing standards and shall include tests of the accounting and statistical records and applicable auditing procedures. Hospitals shall be notified of the results of the final audited cost report which may contain adjustments and revisions which may have resulted from the audited Medicare Cost Report. Hospitals shall have the opportunity to request a review of the final audited cost report. Such a request must be received in writing



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by the Department within 45 days after the date of the Department's notice to the hospital of the results of the finalized audit. Such request shall include all items of documentation and analysis which support the request for review. No additional data shall be accepted after the 45 day period. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

e) Trauma Center Adjustment Reviews

1) The Department shall make trauma care adjustments in accordance with Section 148.290(c). Hospitals shall have the right to appeal the trauma center adjustment calculations if it is believed that a technical error has been made in the calculation.

2) Trauma level designation is obtained from the Illinois Department of Public Health as of the first day of July preceding the trauma center adjustment rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, or the licensing agency in the state in which the hospital is located, substantiating that the information supplied to and utilized by the Department was incorrect.

3) Appeals under this subsection (e) must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for trauma center adjustments and payment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

f) Medicaid High Volume Adjustment Reviews

The Department shall make Medicaid high volume adjustments in accordance with Section 148.290(d). Review shall be limited to verification that the Medicaid inpatient days were calculated in accordance with State regulations. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for Medicaid high volume adjustments and payment adjustment amounts. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

g) Sole Community Hospital Designation Reviews

The Department shall make sole community hospital designations in accordance with 89 Ill. Adm. Code 149.125(b). Hospitals shall have the right to appeal the designation if it believes that a technical error has been made in the determination. The appeal must be made in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the

reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

h) Geographic Designation Reviews

1) The Department shall make rural hospital designation in accordance with Section 148.25(g)(3). Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received within 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

2) The Department shall make urban hospital designations in accordance with Section 148.25(g)(4). Hospitals shall have the right to appeal the designation if it is believed that a technical error has been made in the determination. The appeal must be in writing and must be received 30 days after notification of the designation. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review no later than 30 days after receipt of the hospital's request for review.

i) Critical Hospital Adjustment Payment (CHAP) Reviews

1) The Department shall make CHAPs in accordance with Section 148.295. Hospitals shall be notified in writing of the results of the CHAP determination and calculation, and shall have the right to appeal the CHAP calculation or their ineligibility for the CHAP if it is believed that a technical error has been made in the calculation. The appeal must be in writing and must be received within 30 days after the date of the Department's notice to the hospital of its qualification for CHAP and payment adjustment amounts, or a letter of notification that the hospital does not qualify for the CHAP. Such a request shall include a clear explanation of the reason for the appeal and documentation of the desired correction. The Department shall notify the hospital of the results of the review within 30 days after receipt of the hospital's request for review.

2) CHAP determination reviews shall be limited to the following:

A) Federally Designated Health Professional Shortage Areas (HPSAs). Illinois hospitals located in federally designated HPSAs shall be identified in accordance with 42 CFR 5, and Section 148.295(a)(3)(B) and (b)(3) based upon the methodologies utilized by, and the most current information available to, the Department from the Department of Health and Human Services as of the last day of June preceding the CHAP rate period. Review shall be limited to hospitals in locations that have failed to obtain designation as federally designated HPSAs only when such a request for review is accompanied by documentation from the Department of Health and Human Services substantiating that the hospital was located in a federally designated HPSA as of the last day of June preceding the CHAP rate period.

B) Trauma level designation. Trauma level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.

C) Accreditation of Rehabilitation Facilities. Accreditation of rehabilitation facilities shall be obtained from the Commission on Accreditation of Rehabilitation Facilities as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Commission, substantiating that the information supplied to and utilized by the Department was incorrect.

D) Medicaid Inpatient Utilization Rates. Medicaid inpatient utilization rates shall be calculated pursuant to Section 1923 of the Social Security Act and as defined in Section 148.120(k)(5). Review shall be limited to verification that Medicaid inpatient utilization rates were calculated in accordance with federal and State regulations.

E) Perinatal level designation. Perinatal level designation is obtained from the Illinois Department of Public Health as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and utilized by the Department was incorrect.

F) Disproportionate share eligibility. Disproportionate share eligibility shall be determined pursuant to Section 148.120. Review shall be limited to verification that the Department utilized criteria in accordance with State regulations.

G) Occupancy ratio. The occupancy ratio shall be obtained from the Illinois Department of Public Health's published report entitled "Bed Count, Average Length of Stay, Average Daily Census and Percent Occupancy for Non-Federal Hospitals in Illinois" as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the Illinois Department of Public Health, substantiating that the information supplied to and used by the Department was incorrect.

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H) Graduate Medical Education Programs. Graduate Medical Education program information shall be obtained from the most recently published report of the American Accreditation Council for Graduate Medical Education, the American Osteopathic Association Division of Post-doctoral Training, or the American Dental Association Joint Commission on Dental Accreditation as of the last day of June preceding the CHAP rate period. Review shall be limited to requests accompanied by documentation from the above, substantiating that the information supplied to and utilized by the Department was incorrect.

(Source: Amended at 19 Ill. Reg. 16630, effective NOV 28 1995)



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1) Heading of the Part: Medical Payment

2) Code Citation: 89 Ill. Adm. Code 140

3)

| Section Numbers: | Adopted Action: |
|---|---|
| 140.80 | Amendment |
| 140.82 | Amendment |
| 140.84 | Amendment |
| 140.440 | Amendment |
| 140.443 | Amendment |
| 140.444 | Amendment |
| 140.445 | Amendment |
| 140.446 | Amendment |
| 140.447 | Amendment |

4) Statutory Authority: Section 12-13 of the Illinois Public Aid Code (Ill. Rev. Stat. 1991, ch. 23, par. 12-13) [305 ILCS 5/12-13]

5) Effective Date of Amendments: November 28, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Do these Amendments contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: November 28, 1995

9) Notice of Proposal Published in Illinois Register: July 7, 1995 (19 Ill. Reg. 8938)

10) Has JCAR issued a Statement of Objections to these Adopted Amendments? No

11) Differences between proposal and final version: The following changes have been made in the proposed amendments.

Section 140.80

At the end of subsection (a), the period has been stricken.

Subsection (b) has been revised to read:

(b) Provider Assessments

Effective July 1, 1994, through June 30, 1997, an annual assessment is imposed upon each hospital provider in an amount equal to the provider's adjusted gross hospital revenue, as described in subsection (1)(1) of this Section, for the most recent calendar year ending before the beginning of that fiscal

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year, multiplied by a Provider's Savings Rate.

1) Effective July 1, 1994, through June 30, 1995, the Provider's Savings Rate is obtained by multiplying 1.88 percent by a fraction, the numerator of which is the Maximum Section 5A-2 Contribution minus the Cigarette Tax Contribution, and the denominator of which equals the Maximum Section 5-2 Contribution (see subsections (l)(2), (8) and (10) of this Section).

2) Effective July 1, 1995, through June 30, 1997, the Provider's Savings Rate is obtained by multiplying 1.25 percent by the fraction described in subsection (b)(1) above.

3) The Department reserves the right to audit the reported data. The Department shall notify hospital providers of the Provider's Savings Rate by mailing a notice to each provider's last known address as reflected by the records of the Department.

At the end of subsection (c), the period has been stricken.

In the first sentence of subsection (d)(4), change "subsections (d)(5) or (6)" to "subsection (d)(5) or (6)".

At the end of subsection (g)(1), the comma has been changed to a semicolon.

In subsection (i), "Public Act 89-21" has been changed to "P.A. 89-21".

In subsection (j)(2), "Public Act 89-21" has been changed to "P.A. 89-21".

In subsection (j)(3), "Public Act 88-554" has been changed to "P.A. 88-554".

In subsection (l)(11)(C), change "subsections (l)(11)(A) or (B)" to "subsection (l)(11)(A) or (B)".

Section 140.82

In the first sentence of subsection (e)(3), "A developmentally disabled care provider" has been changed to "For a developmentally disabled care provider".

At the end of subsection (g)(1), the comma has been changed to a semicolon.



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In subsection (i), "Public Act 89-21" has been changed to P.A. 89-21".

In subsection (j), the comma after "P.A. 89-21" has been deleted.

In subsection (k)(4), the extra space in "not-for- profit" has been omitted.

Section 140.84

At the end of subsection (g)(1), the comma has been changed to a semicolon.

The third sentence of subsection (h)(5) has been revised to read, "The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above, is 1.5 or less and the facility meets the criteria in subsections (h)(1)(A) and (B)."

The introduction to subsection (i) has been changed to read, "Administration - enforcement provisions".

In subsection (i), "Public Act 89-21" has been changed to "P.A. 89-21".

Section 140.440

In subsection (b)(1), the outdated statutory citation "(Ill. Rev. Stat. 1991, ch. 56 1/2, par. 1301 et seq.)" has been stricken.

In subsection (f), the parentheses enclosing the ILCS citation have been changed to brackets.

Section 140.445

At the end of subsection (a)(1), the comma has been changed to a semicolon.

In subsection (a)(2), "~~price~~" has been changed to "price".

At the end of subsections (b)(1), (b)(2) and (b)(3), the commas have been changed to semicolons.

In subsection (b)(3), "Therapeutic Evaluations" has been changed to "Therapeutic Equivalence Evaluations".

Section 140.446

The label "a", at the introductory statement, has been deleted.

At the end of the introductory statement, the comma has been changed to a

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semicolon.

The labels for subsections (a)(1) and (a)(2), have been changed to (a) and (b).

No other changes have been made in the text of the proposed amendments.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will these Amendments replace Emergency Amendments currently in effect? Yes

14) Are there any Amendments pending on this Part? Yes

| Sections | Proposed Action | Illinois Register Citation |
|---|---|---|
| 140.2 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.7 | Amendment | August 25, 1995 (19 Ill. Reg. 12210) |
| 140.9 | Amendment | August 25, 1995 (19 Ill. Reg. 12210) |
| 140.16 | Amendment | September 15, 1995 (19 Ill. Reg. 12937) |
| 140.40 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.413 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.460 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.461 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.462 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.463 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.464 | Repeal | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.475 | Amendment | November 17, 1995 (19 Ill. Reg. 15581) |
| 140.478 | Amendment | November 17, 1995 (19 Ill. Reg. 15581) |
| 140.481 | Amendment | November 17, 1995 (19 Ill. Reg. 15581) |
| 140.485 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.490 | Amendment | December 8, 1995 (19 Ill. Reg. 16134) |
| 140.491 | Amendment | December 8, 1995 (19 Ill. Reg. 16134) |
| 140.492 | Amendment | December 8, 1995 (19 Ill. Reg. 16134) |
| 140.493 | New Section | December 8, 1995 (19 Ill. Reg. 16134) |
| 140.642 | Amendment | November 27, 1995 (19 Ill. Reg. 15788) |
| 140.920 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.922 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.924 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.926 | Repeal | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.928 | Repeal | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.930 | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.932 | Repeal | October 20, 1995 (19 Ill. Reg. 14530) |
| 140.Table M | Amendment | October 20, 1995 (19 Ill. Reg. 14530) |

15) Summary and Purpose of Amendments:



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Sections 140.80 through 140.84

The Department of Public Aid is making changes to the rules pertaining to provider assessments for hospitals, long term care facilities for persons with developmental disabilities, and nursing homes. These changes affect the assessment methodology for hospitals, and continue the provider assessment program beyond June 30, 1995. This rulemaking responds to the Governor's budget initiative, which is intended to enable Illinois to continue to maximize federal financing benefits to hospitals, long term care facilities and nursing homes, and thereby ensure the continuance of necessary care and services. These new provisions in the provider assessment program are required by the enactment of the State's budget by the Legislature and Public Act 89-21.

Changes are also being made to Section 140.80 to comply with Public Act 88-554, which created the University of Illinois Fund. These changes affect hospitals organized under the University of Illinois Hospital Act which are exempt from the provider assessments imposed by Section 140.80. Previously, the interagency agreement between the Department and such hospitals provided for intergovernmental transfer payments to the Department which were deposited into the State's General Revenue Fund. Because of Public Act 88-554, intergovernmental transfer payments from the University of Illinois Hospital are to be deposited into the University of Illinois Fund.

Other changes are being made to Sections 140.80, 140.82 and 140.84 to accommodate calendar changes from one fiscal year to another. The provider assessment program described in these Sections was initially effective for fiscal year 1994, and dates specified in the rules as due dates for the Department's receipt of assessment payments and delayed payment requests from providers, are no longer accurate. Therefore, the rules are being revised to indicate that providers will be notified in writing by the Department of applicable dates for each fiscal year.

In Section 140.84, changes clarify that only skilled nursing and intermediate care licensed beds in nursing homes are subject to payment responsibility under the provider assessment program. Beds in nursing homes which are specifically designated for sheltered care purposes are not subject to assessments.

Changes are also being made to exempt facilities operated by the Department of Mental Health and Developmental Disabilities (DMHDD) from assessment responsibility. These amendments in Section 140.80, correspond to emergency rulemakings, effective March 1, 1995, at 89 Ill. Adm. Code 148 and Section 140.80, enabling Illinois to maximize federal financing benefits to hospitals as permitted by the State's federal disproportionate share (DSH) spending limitations. Facilities operated by DMHDD are eligible to qualify for DSH hospital payment adjustments. Changes are

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necessary in Section 140.80, to exempt DMHDD facilities from the hospital assessment program. Since the Department assesses hospitals to increase State revenue, taxing another State entity would simply transfer funds from one State entity to another, with no net increase in revenue. DMHDD facilities are now considered to be providers of hospital services which qualify for DSH adjustments, and must be specifically exempted from the hospital assessments imposed under Section 140.80.

In fiscal year 1995, the provider assessment program generated approximately $689.7 million in spending ($355.4 million in assessments and $334.3 million in federal matching funds). These amendments will have a significant budgetary impact upon the Department, because if the assessment program had concluded on June 30, 1995, the expected loss of revenue for fiscal year 1996 would be approximately $738.8 million ($380.7 million in assessments and $358.1 million in federal matching funds).

Sections 140.440 through 140.447

These amendments have been filed in conjunction with the State's budget plan for fiscal year 1996, by providing certain cost containment measures in some areas of the Department's pharmacy program. The initiatives contained in these amendments are necessary to control costs associated with pharmacy services covered by the Department, and thereby meet restrictions imposed by the new budget plan.

The Department is changing the method for calculating the maximum reimbursement amount for legend drugs. Reimbursement will continue to be provided for the lesser of the pharmacy charge to the general public, or the calculated maximum reimbursement amount. The revisions affecting calculation of the maximum reimbursement amount differ for brand name and generic drugs. For brand name drugs, the Department's calculation of the dispensing fee component of the maximum reimbursement amount is being reduced by 28 cents per prescription item. The calculation of the acquisition cost component for the maximum reimbursement of generic drugs will be the lower of the average wholesale price minus 12 percent, the Federal Upper Limit, or the State Upper Limit.

The reduction in overall spending for pharmacy services resulting from these changes is expected to be approximately $2.3 million for fiscal year 1996.

16) Information and questions regarding these Adopted Amendments shall be directed to:

Joanne Jones
Bureau of Rules and Regulations
Illinois Department of Public Aid
100 South Grand Avenue East, Third Floor



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Springfield, Illinois 62762
(217) 524-3215

The full text of the Adopted Amendments begins on the next page:

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TITLE 89: SOCIAL SERVICES
CHAPTER I: DEPARTMENT OF PUBLIC AID
SUBCHAPTER d: MEDICAL PROGRAMS

PART 140
MEDICAL PAYMENT

SUBPART A: GENERAL PROVISIONS



SUBPART B: MEDICAL PROVIDER PARTICIPATION





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SUBPART C: PROVIDER ASSESSMENTS

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SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES





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SUBPART E: GROUP CARE





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SUBPART F: MEDICAID PARTNERSHIP PROGRAM



SUBPART G: HEALTHY MOMS/HEALTHY KIDS PROGRAM





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SUBPART H: ILLINOIS COMPETITIVE ACCESS AND REIMBURSEMENT EQUITY (ICARE) PROGRAM

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TABLE K Services Qualifying for 10% Add-On (Repealed)
TABLE L Services Qualifying for 10% Add-On to Surgical Incentive Add-On (Repealed)
TABLE M Enhanced Rates for Healthy Moms/Healthy Kids Provider Services

AUTHORITY: Implementing Article III of the Illinois Health Finance Reform Act [20 ILCS 2215/Art. 3] and implementing and authorized by Articles III, IV, V, VI, VII and Section 12-13 of the Illinois Public Aid Code [305 ILCS 5/Arts. III, IV, V, VI, VII and 12-13].

SOURCE: Adopted at 3 Ill. Reg. 24, p. 166, effective June 10, 1979; rule repealed and new rule adopted at 6 Ill. Reg. 8374, effective July 6, 1982; emergency amendment at 6 Ill. Reg. 8508, effective July 6, 1982, for a maximum of 150 days; amended at 7 Ill. Reg. 681, effective December 30, 1982; amended at 7 Ill. Reg. 7956, effective July 1, 1983; amended at 7 Ill. Reg. 8308, effective July 1, 1983; amended at 7 Ill. Reg. 8271, effective July 5, 1983; emergency amendment at 7 Ill. Reg. 8354, effective July 5, 1983, for a maximum of 150 days; amended at 7 Ill. Reg. 8540, effective July 15, 1983; amended at 7 Ill. Reg. 9382, effective July 22, 1983; amended at 7 Ill. Reg. 12868, effective September 20, 1983; peremptory amendment at 7 Ill. Reg. 15047, effective October 31, 1983; amended at 7 Ill. Reg. 17358, effective December 21, 1983; amended at 8 Ill. Reg. 254, effective December 21, 1983; emergency amendment at 8 Ill. Reg. 580, effective January 1, 1984, for a maximum of 150 days; codified at 8 Ill. Reg. 2483; amended at 8 Ill. Reg. 3012, effective February 22, 1984; amended at 8 Ill. Reg. 5262, effective April 9, 1984; amended at 8 Ill. Reg. 6785, effective April 27, 1984; amended at 8 Ill. Reg. 6983, effective May 9, 1984; amended at 8 Ill. Reg. 7258, effective May 16, 1984; emergency amendment at 8 Ill. Reg. 7910, effective May 22, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 7910, effective June 1, 1984; amended at 8 Ill. Reg. 10032, effective June 18, 1984; emergency amendment at 8 Ill. Reg. 10062, effective June 20, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 13343, effective July 17, 1984; amended at 8 Ill. Reg. 13779, effective July 24, 1984; Sections 140.72 and 140.73 recodified to 89 Ill. Adm. Code 141 at 8 Ill. Reg. 16354; amended (by adding sections being codified with no substantive change) at 8 Ill. Reg. 17899; peremptory amendment at 8 Ill. Reg. 18151, effective September 18, 1984; amended at 8 Ill. Reg. 21629, effective October 19, 1984; peremptory amendment at 8 Ill. Reg. 21677, effective October 24, 1984; amended at 8 Ill. Reg. 22097, effective October 24, 1984; peremptory amendment at 8 Ill. Reg. 22155, effective October 29, 1984; amended at 8 Ill. Reg. 23218, effective November 20, 1984; emergency amendment at 8 Ill. Reg. 23721, effective November 21, 1984, for a maximum of 150 days; amended at 8 Ill. Reg. 25067, effective December 19, 1984; emergency amendment at 9 Ill. Reg. 407, effective January 1, 1985, for a maximum of 150 days; amended at 9 Ill. Reg. 2697, effective February 22, 1985; amended at 9 Ill. Reg. 6235, effective April 19, 1985; amended at 9 Ill. Reg. 8677, effective May 28, 1985; amended at 9 Ill. Reg. 9564, effective June 5, 1985; amended at 9 Ill. Reg. 10025, effective June 26, 1985; emergency amendment at 9 Ill. Reg. 11403, effective June 27, 1985, for a maximum of 150 days; amended at 9 Ill.



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Reg. 11357, effective June 28, 1985; amended at 9 Ill. Reg. 12000, effective July 24, 1985; amended at 9 Ill. Reg. 12306, effective August 5, 1985; amended at 9 Ill. Reg. 13998, effective September 3, 1985; amended at 9 Ill. Reg. 14684, effective September 13, 1985; amended at 9 Ill. Reg. 15503, effective October 4, 1985; amended at 9 Ill. Reg. 16312, effective October 11, 1985; amended at 9 Ill. Reg. 19138, effective December 2, 1985; amended at 9 Ill. Reg. 19737, effective December 9, 1985; amended at 10 Ill. Reg. 238, effective December 27, 1985; emergency amendment at 10 Ill. Reg. 798, effective January 1, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 672, effective January 6, 1986; amended at 10 Ill. Reg. 1206, effective January 13, 1986; amended at 10 Ill. Reg. 3041, effective January 24, 1986; amended at 10 Ill. Reg. 6981, effective April 16, 1986; amended at 10 Ill. Reg. 7825, effective April 30, 1986; amended at 10 Ill. Reg. 8128, effective May 7, 1986; emergency amendment at 10 Ill. Reg. 8912, effective May 13, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 11440, effective June 20, 1986; amended at 10 Ill. Reg. 14714, effective August 27, 1986; amended at 10 Ill. Reg. 15211, effective September 12, 1986; emergency amendment at 10 Ill. Reg. 16729, effective September 18, 1986, for a maximum of 150 days; amended at 10 Ill. Reg. 18808, effective October 24, 1986; amended at 10 Ill. Reg. 19742, effective November 12, 1986; amended at 10 Ill. Reg. 21784, effective December 15, 1986; amended at 11 Ill. Reg. 698, effective December 19, 1986; amended at 11 Ill. Reg. 1418, effective December 31, 1986; amended at 11 Ill. Reg. 2323, effective January 16, 1987; amended at 11 Ill. Reg. 4002, effective February 25, 1987; Section 140.71 recodified to 89 Ill. Adm. Code 141 at 11 Ill. Reg. 4302; amended at 11 Ill. Reg. 4303, effective March 6, 1987; amended at 11 Ill. Reg.7664, effective April 15, 1987; emergency amendment at 11 Ill. Reg. 9342, effective April 20, 1987, for a maximum of 150 days; amended at 11 Ill. Reg. 9169, effective April 28, 1987; amended at 11 Ill. Reg. 10903, effective June 1, 1987; amended at 11 Ill. Reg. 11528, effective June 22, 1987; amended at 11 Ill. Reg. 12011, effective June 30, 1987; amended at 11 Ill. Reg. 12290, effective July 6, 1987; amended at 11 Ill. Reg. 14048, effective August 14, 1987; amended at 11 Ill. Reg. 14771, effective August 25, 1987; amended at 11 Ill. Reg. 16758, effective September 28, 1987; amended at 11 Ill. Reg. 17295, effective September 30, 1987; amended at 11 Ill. Reg. 18696, effective October 27, 1987; amended at 11 Ill. Reg. 20909, effective December 14, 1987; amended at 12 Ill. Reg. 916, effective January 1, 1988; emergency amendment at 12 Ill. Reg. 1960, effective January 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 5427, effective March 15, 1988; amended at 12 Ill. Reg. 6246, effective March 16, 1988; amended at 12 Ill. Reg. 6728, effective March 22, 1988; Sections 140.900 thru 140.912 and 140.Table H and 140.Table I recodified to 89 Ill. Adm. Code 147.5 thru 147.205 and 147.Table A and 147.Table B at 12 Ill. Reg. 6956; amended at 12 Ill. Reg. 6927, effective April 5, 1988; Sections 140.940 thru 140.972 recodified to 89 Ill. Adm. Code 149.5 thru 149.325 at 12 Ill. Reg. 7401; amended at 12 Ill. Reg. 7695, effective April 21, 1988; amended at 12 Ill. Reg. 10497, effective June 3, 1988; amended at 12 Ill. Reg. 10717, effective June 14, 1988; emergency amendment at 12 Ill. Reg. 11868, effective July 1, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 12509, effective July 15, 1988; amended at 12 Ill. Reg. 14271, effective August 29,

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1988; emergency amendment at 12 Ill. Reg. 16921, effective September 28, 1988, for a maximum of 150 days; amended at 12 Ill. Reg. 16738, effective October 5, 1988; amended at 12 Ill. Reg. 17879, effective October 24, 1988; amended at 12 Ill. Reg. 18198, effective November 4, 1988; amended at 12 Ill. Reg. 19396, effective November 6, 1988; amended at 12 Ill. Reg. 19734, effective November 15, 1988; amended at 13 Ill. Reg. 125, effective January 1, 1989; amended at 13 Ill. Reg. 2475, effective February 14, 1989; amended at 13 Ill. Reg. 3069, effective February 28, 1989; amended at 13 Ill. Reg. 3351, effective March 6, 1989; amended at 13 Ill. Reg. 3917, effective March 17, 1989; amended at 13 Ill. Reg. 5115, effective April 3, 1989; amended at 13 Ill. Reg. 5718, effective April 10, 1989; amended at 13 Ill. Reg. 7025, effective April 24, 1989; Sections 140.850 thru 140.896 recodified to 89 Ill. Adm. Code 146.5 thru 146.225 at 13 Ill. Reg. 7040; amended at 13 Ill. Reg. 7786, effective May 20, 1989; Sections 140.94 thru 140.398 recodified to 89 Ill. Adm. Code 148.10 thru 148.390 at 13 Ill. Reg. 9572; emergency amendment at 13 Ill. Reg. 10977, effective July 1, 1989, for a maximum of 150 days; emergency expired November 28, 1989; amended at 13 Ill. Reg. 11516, effective July 3, 1989; amended at 13 Ill. Reg. 12119, effective July 7, 1989; Section 140.110 recodified to 89 Ill. Adm. Code 148.120 at 13 Ill. Reg. 12118; amended at 13 Ill. Reg. 12562, effective July 17, 1989; amended at 13 Ill. Reg. 14391, effective August 31, 1989; emergency amendment at 13 Ill. Reg. 15473, effective September 12, 1989, for a maximum of 150 days; amended at 13 Ill. Reg. 16992, effective October 16, 1989; amended at 14 Ill. Reg. 190, effective December 21, 1989; amended at 14 Ill. Reg. 2564, effective February 9, 1990; emergency amendment at 14 Ill. Reg. 3241, effective February 14, 1990, for a maximum of 150 days; emergency expired July 14, 1990; amended at 14 Ill. Reg. 4543, effective March 12, 1990; emergency amendment at 14 Ill. Reg. 4577, effective March 6, 1990, for a maximum of 150 days; emergency expired August 3, 1990; emergency amendment at 14 Ill. Reg. 5575, effective April 1, 1990, for a maximum of 150 days; emergency expired August 29, 1990; emergency amendment at 14 Ill. Reg. 5865, effective April 3, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 7141, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990; emergency amendment at 14 Ill. Reg. 7249, effective April 27, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 10062, effective June 12, 1990; amended at 14 Ill. Reg. 10409, effective June 19, 1990; emergency amendment at 14 Ill. Reg. 12082, effective July 5, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 13262, effective August 6, 1990; emergency amendment at 14 Ill. Reg. 14184, effective August 16, 1990, for a maximum of 150 days; emergency amendment at 14 Ill. Reg. 14570, effective August 22, 1990, for a maximum of 150 days; amended at 14 Ill. Reg. 14826, effective August 31, 1990; amended at 14 Ill. Reg. 15366, effective September 12, 1990; amended at 14 Ill. Reg. 15981, effective September 21, 1990; amended at 14 Ill. Reg. 17279, effective October 12, 1990; amended at 14 Ill. Reg. 18057, effective October 22, 1990; amended at 14 Ill. Reg. 18508, effective October 30, 1990; amended at 14 Ill. Reg. 18813, effective November 6, 1990; amended at 14 Ill. Reg. 20478, effective December 7, 1990; amended at 14 Ill. Reg. 20729, effective December 12, 1990; amended at 15 Ill. Reg. 298, effective December 28, 1990; emergency amendment at 15 Ill. Reg. 592, effective January



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1, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 1051, effective January 18, 1991; Section 140.569 withdrawn at 15 Ill. Reg. 1174; amended at 15 Ill. Reg. 6220, effective April 18, 1991; amended at 15 Ill. Reg. 6534, effective April 30, 1991; amended at 15 Ill. Reg. 8264, effective May 23, 1991; amended at 15 Ill. Reg. 8972, effective June 17, 1991; amended at 15 Ill. Reg. 10114, effective June 21, 1991; amended at 15 Ill. Reg. 10468, effective July 1, 1991; amended at 15 Ill. Reg. 11176, effective August 1, 1991; emergency amendment at 15 Ill. Reg. 11515, effective July 25, 1991, for a maximum of 150 days; emergency expired December 22, 1991; emergency amendment at 15 Ill. Reg. 12919, effective August 15, 1991, for a maximum of 150 days; emergency expired January 12, 1992; emergency amendment at 15 Ill. Reg. 16366, effective October 22, 1991, for a maximum of 150 days; amended at 15 Ill. Reg. 17318, effective November 18, 1991; amended at 15 Ill. Reg. 17733, effective November 22, 1991; emergency amendment at 16 Ill. Reg. 300, effective December 20, 1991, for a maximum of 150 days; amended at 16 Ill. Reg. 174, effective December 24, 1991; amended at 16 Ill. Reg. 1877, effective January 24, 1992; amended at 16 Ill. Reg. 3552, effective February 28, 1992; amended at 16 Ill. Reg. 4006, effective March 6, 1992; amended at 16 Ill. Reg. 6408, effective March 20, 1992; amended at 16 Ill. Reg. 6849, effective April 7, 1992; amended at 16 Ill. Reg. 7017, effective April 17, 1992; amended at 16 Ill. Reg. 10050, effective June 5, 1992; amended at 16 Ill. Reg. 11174, effective June 26, 1992; expedited correction at 16 Ill. Reg. 11348, effective March 20, 1992; emergency amendment at 16 Ill. Reg. 11947, effective July 10, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 12186, effective July 24, 1992; emergency amendment at 16 Ill. Reg. 13337, effective August 14, 1992, for a maximum of 150 days; emergency amendment at 16 Ill. Reg. 15109, effective September 21, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 15561, effective September 30, 1992; amended at 16 Ill. Reg. 17302, effective November 2, 1992; emergency amendment at 16 Ill. Reg. 18097, effective November 17, 1992, for a maximum of 150 days; amended at 16 Ill. Reg. 19146, effective December 1, 1992; amended at 16 Ill. Reg. 19879, effective December 7, 1992; amended at 17 Ill. Reg. 837, effective January 11, 1993; amended at 17 Ill. Reg. 1112, effective January 15, 1993; amended at 17 Ill. Reg. 2290, effective February 15, 1993; amended at 17 Ill. Reg. 2951, effective February 17, 1993; amended at 17 Ill. Reg. 3421, effective February 19, 1993; amended at 17 Ill. Reg. 6196, effective April 5, 1993; amended at 17 Ill. Reg. 6839, effective April 21, 1993; amended at 17 Ill. Reg. 7004, effective May 17, 1993; expedited correction at 17 Ill. Reg. 7078, effective December 1, 1992; emergency amendment at 17 Ill. Reg. 11201, effective July 1, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 15162, effective September 2, 1993, for a maximum of 150 days; emergency amendment at 17 Ill. Reg. 18152, effective October 1, 1993, for a maximum of 150 days; amended at 17 Ill. Reg. 18571, effective October 8, 1993; emergency amendment at 17 Ill. Reg. 18611, effective October 1, 1993, for a maximum of 150 days; emergency amendment suspended effective October 12, 1993; amended at 17 Ill. Reg. 20999, effective November 24, 1993; emergency amendment repealed at 17 Ill. Reg. 22583, effective December 20, 1993; amended at 18 Ill. Reg. 3620, effective February 28, 1994; amended at 18 Ill. Reg. 4250, effective March 4, 1994; amended at 18 Ill. Reg. 5951, effective April 1, 1994; emergency

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amendment at 18 Ill. Reg. 10922, effective July 1, 1994, for a maximum of 150 days; emergency amendment suspended, effective November 15, 1994; emergency amendment repealed at 19 Ill. Reg. 5839, effective April 4, 1995; amended at 18 Ill. Reg. 11244, effective July 1, 1994; amended at 18 Ill. Reg. 14126, effective August 29, 1994; amended at 18 Ill. Reg. 16675, effective November 1, 1994; amended at 18 Ill. Reg. 18059, effective December 19, 1994; amended at 19 Ill. Reg. 1082, effective January 20, 1995; amended at 19 Ill. Reg. 2933, effective March 1, 1995; emergency amendment at 19 Ill. Reg. 3529, effective March 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 5663, effective April 1, 1995; amended at 19 Ill. Reg. 7919, effective June 5, 1995; emergency amendment at 19 Ill. Reg. 8455, effective June 9, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 9297, effective July 1, 1995, for a maximum of 150 days; emergency amendment at 19 Ill. Reg. 10252, effective July 1, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 13019, effective September 5, 1995; amended at 19 Ill. Reg. 14440, effective September 29, 1995; emergency amendment at 19 Ill. Reg. 14833, effective October 6, 1995, for a maximum of 150 days; amended at 19 Ill. Reg. 15441, effective October 26, 1995; amended at 19 Ill. Reg. 15692, effective November 6, 1995; amended at 19 Ill. Reg. 16677, effective NOV 28 1995.

SUBPART C: PROVIDER ASSESSMENTS

**Section 140.80 Hospital Provider Fund**

a) Purpose and Contents
   1) The Hospital Provider Fund ("Fund") was created in the State Treasury upon enactment of Public Act 87-861, ~~and by~~ Public Act 88-88 and Public Act 89-21. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.
   2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, as amended by Public Act 88-88 and Public Act 89-21.
   3) The Fund shall consist of:
      A) All monies collected or received by the Department under subsection (b) below;
      B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;
      C) Any interest or penalty levied in conjunction with the administration of the Fund;
      D) All other monies received for the Fund from any other source, including interest earned thereon;
      E) All monies transferred from the Hospital Services Trust Fund; and
      F) All monies transferred from the Tobacco Products Tax Act.

b) Provider Assessments



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Effective July 1, 1994, through June 30, 1997, an annual assessment is imposed upon each hospital provider in an amount equal to the provider's adjusted gross hospital revenue, as described in subsection (1)(1) of this Section, for the most recent calendar year ending before the beginning of that fiscal year, multiplied by a Provider's Savings Rate.

1) Effective July 1, 1994, through June 30, 1995, the Provider's Savings Rate is obtained by multiplying 1.88 percent by a fraction, the numerator of which is the Maximum Section 5A-2 Contribution minus the Cigarette Tax Contribution, and the denominator of which equals the Maximum Section 5-2 Contribution (see subsections (1)(2), (8) and (10) of this Section).
2) Effective July 1, 1995, through June 30, 1997, the Provider's Savings Rate is obtained by multiplying 1.25 percent by the fraction described in subsection (b)(1) above.
3) The Department reserves the right to audit the reported data. The Department shall notify hospital providers of the Provider's Savings Rate by mailing a notice to each provider's last known address as reflected by the records of the Department.

~~Beginning on July 1, 1993, and ending on June 30, 1994, an assessment is imposed upon each hospital provider in an amount equal to 1.88% of the provider's adjusted gross hospital revenue, as described in subsection (1)(1) of this Section, for the most recent calendar year ending before the beginning of that State fiscal year. An assessment is imposed upon each hospital provider for the fiscal year beginning on July 1, 1994, and ending on June 30, 1995, in an amount equal to the provider's adjusted gross hospital revenue, as described in subsection (1)(1) of this Section, for the most recent calendar year ending before the beginning of that State fiscal year multiplied by the Provider's Savings Rate, as described in subsection (1)(10) of this Section. The Department reserves the right to audit the reported data. The Department shall notify hospital providers of the Provider's Savings Rate by mailing a notice to each provider's last known address as reflected by the records of the Department.~~

c) Payment of Assessment Due
   1) The assessments imposed in subsection (b) above shall be due and payable in quarterly installments, each equalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the quarterly due dates. Assessment payments postmarked on the due date will be considered as paid on time.
   2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Reporting Requirements, Penalty, and Maintenance of Records
   1) After December 31 of each year, and on or before March 31 of the succeeding year, every hospital provider subject to an assessment

under subsection (b) above shall file a report with the Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross hospital revenue from the calendar year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the next July 1. If a hospital provider conducts, operates, or maintains more than one hospital licensed by the Illinois Department of Public Health, a separate report shall be filed for each hospital. In the case of a hospital provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the hospital provider fails to file its report for a State fiscal year on or before the due date of the report, there shall be, unless waived by the Department for reasonable cause, added to the assessment imposed in subsection (b) above a penalty assessment equal to 25 percent % of the assessment imposed for the year.

3) Every hospital provider subject to an assessment under subsection (b) above shall keep records and books that will permit the determination of adjusted gross hospital revenue on a calendar year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsection ~~subsections~~ (d)(5) or (6) below, an amended assessment report must be filed within 30 calendar days of the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Submission of Financial Audit Statements. All hospital providers are required to submit a copy of all financial statements audited by an external, independent auditor, to the Department within 30 days after the close of such externally performed financial audits. If the hospital's year end does not coincide with the December 31 ending date for the assessment report, the hospital must submit all financial audits covering the assessment report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial assessment report changes based upon the findings of such external financial audits and as indicated in the audited



external financial statements. Penalties may be applied to the amount underpaid due to a filing error.

6) Reconsideration of Adjusted Assessment. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a hospital provider, the hospital provider may request a review or reconsideration of the adjusted assessment within 30 days after the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. If a hospital provider ceases to conduct, operate, or maintain a hospital for which the person is subject to assessment under subsection (b) above, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the hospital and the denominator of which is 365. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final return the assessment for the year as so adjusted, to the extent not previously paid.

2) Commencing of business during the fiscal year in which the assessment is being paid. A hospital provider who commences conducting, operating, or maintaining a hospital for which the person is subject to assessment under subsection (b) above, shall file an initial report for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) above as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occurring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

3) Partial Calendar Year Operation Adjustment. For a hospital provider that did not conduct, operate, or maintain a hospital throughout the entire calendar year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual revenues for the

portion of the reporting period the hospital was operational (dividing adjusted gross hospital revenue by the number of days the hospital was in operation and then multiplying the amount by 365). Revenues realized by a prior provider from the same hospital during the calendar year shall be used in the annualization equation, if available.

4) Change in Ownership and/or Operations. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rest on the hospital provider currently operating or maintaining the hospital regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liability incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any hospital that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent 5% of the amount of the installment not paid on or before the due date, plus five percent 5% of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100 percent % of the installment amount not paid on or before the due date.

2) Within 45 days from the due date, the Department may begin recovery actions against delinquent hospitals participating in the Medicaid Program. Payments may be withheld from the hospital until the entire assessment, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached or if a hospital fails to comply with an agreement, the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the hospital's future payments from the Department. The provider may appeal this recoupment in accordance with Department rules contained in 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against the same hospital two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.



3) If the hospital does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Hospitals

The Director may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of hospitals such as disproportionate share hospitals or all other hospitals when:

1) the State delays payments to hospitals due to problems related to State cash flow; or

2) a cash flow bond pool's, or any other group financing plans', requests from providers for loans are in excess of its scheduled proceeds such that a significant number of hospitals will be unable to obtain a loan to pay the assessment.

h) Delayed Payment - Individual Hospitals

In addition to the provisions of subsection (g) above, the Director may delay assessments for individual hospitals that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions may be made only to qualified hospitals who meet all of the following requirements:

A) the provider has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1) and (f)(2) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the provider's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a provider which are unrelated to Department technical system problems and which result in extensive financial problems to a facility, adversely impacting on its ability to serve its clients.

B) the provider serves a significant number of clients under the medical assistance program. "Significant" in this

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instance means:

i) a hospital that serves a significant number of clients under the medical assistance program; significant in this instance means that the hospital qualifies as a disproportionate share hospital under 89 Ill. Adm. Code 148.120(a)(1) through 148.120(a)(5); or qualifies as a Medicare DSH hospital under the current federal guidelines.

ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

iii) a hospital which has filed for Chapter 11 bankruptcy, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

C) the provider must file a delay of payment request as defined under subsection (h)(3)(A) below, and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0.

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation.

D) the provider must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institution such as a commercial bank. The denial must be 90 days old or less.

E) the provider must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) that shall be due from the provider as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement; ~~and~~

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signature's knowledge; and~~.~~

vi) such other terms and conditions that may be required by the Department.

2) A hospital which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the hospital not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the hospital. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, providers must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the date designated by the Department. Providers will be notified, in writing, as to the due dates for submitting delay of payment requests ~~as--follows:--delayed--payment requests-for-installments-due-on-September-30--of--the--year must--be--received--on--or--before-September-10-of-the-year; delayed-payment-requests-for-installments-due-on-December-31 of-the-year-must-be-received-on-or-before-December-10-of-the year;-delayed-payment-requests-for-installments-due-on-March 31-of-the-year-must-be-received-on-or-before-March-11-of-the year;-and-delayed-payment-requests-for-installments--due--on May--31--of-the-year-must-be-received-on-or-before-May-10-of the--year~~. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, postmarked no later than the date of the telefax. The request must include:

i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) of this Section, a denial of application to borrow the assessment as defined in subsection (h)(1)(D) of this



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Section and an explanation of the risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the provider.

B) The hospital shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the provider for all approved requests. The agreement must be signed by the administrator, owner, chief executive officer or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the provider's request for institution of delayed payment provisions. In the event a provider's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the provider fails to meet all of the terms and conditions of the agreement. In the event the provider fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above, is 1.5 or less and the hospital meets the criteria in subsections (h)(1)(A) and (B) above. Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a provider has requested and received approval for delayed payment arrangements, the provider shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delayed payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a provider that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration and Enforcement Provisions

Pursuant to Section 5A-7 of P.A. 86-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861, ~~and--by~~ P.A. 88-88 and P.A. 89-21, and collect the assessments, interest, and



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penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Exemptions

1) A rural hospital, as defined in subsection (l)(ll) below, shall be exempt from the assessment imposed under subsection (b), unless the exemption is a judged to be unconstitutional or otherwise invalid, in which case the provider shall pay the assessment imposed under subsection (b) above.

2) A hospital provider which is a county with a population of more than 3,000,000 that makes intergovernmental transfer payments as provided in Section 15-3 of P.A. 87-861, as amended by P.A. 88-85, ~~and~~ P.A. 88-88 and P.A. 89-21, shall be exempt from the assessment imposed by subsection (b) above, unless the exemption is adjudged to be unconstitutional or otherwise invalid, in which case the hospital shall pay the assessment imposed by subsection (b) above for all assessment periods beginning on or after July 1, 1992, and the assessment so paid shall be creditable against the intergovernmental transfer payments.

3) The Department is authorized to enter into an interagency agreement with a hospital organized under the University of Illinois Hospital Act exempt from the assessment imposed under subsection (b) of this Section, to make intergovernmental transfer payments to the Department. Effective July 1, 1994, these ~~These~~ payments shall be deposited into the University of Illinois Fund, as mandated under P.A. 88-554 ~~General Revenue Fund~~.

4) The Department is also authorized to enter into agreements with publicly owned or operated hospitals not described in subsections (j)(1) through (j)(3) above to make intergovernmental transfer payments to the Department. These payments shall be deposited into the Hospital Provider Fund.

5) Facilities operated by the Department of Mental Health and Developmental Disabilities shall be exempt from the assessment imposed by subsection (b) above.

k) Nothing in P.A. 89-21 ~~88-88~~ shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of P.A. 89-21 ~~88-88~~.

l) Definitions

As used in this Section, unless the context requires otherwise:

1) "Adjusted gross hospital revenue" means the hospital provider's total gross patient charges less Medicare contractual allowances, but does not include gross patient revenue ~~(and--the--portion--of any--Medicare-contractual-allowance-related-thereto)~~ from skilled or intermediate long-term care services within the meaning of

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Title XVIII or XIX of the Social Security Act, or home health and hospice services (and the portion of any Medicare contractual allowance related thereto). Revenue generated from swing beds, as described in subsection (l)(12) below, is considered to be part of the provider's gross hospital revenue. Revenue not related to patient care, such as investment income, gift shop, cafeteria, or parking lot revenue, is not considered as patient revenue. Adjusted gross hospital revenue must be reported on an accrual basis for the assessment reporting period. All patient revenue accrued during the assessment reporting period must be included even though reimbursement may occur after the assessment reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the hospital's last two cost reports.

2) "Cigarette Tax Contribution" is the sum of the total amount deposited in the Hospital Provider Fund in the previous State fiscal year ~~1994~~ pursuant to Section 2(a) of the Cigarette Tax Act, plus the total amount deposited in the Hospital Provider Fund in the previous State fiscal year ~~1994~~ pursuant to Section 5A-3(c) of Public Act 88-88, as amended by Public Act 89-21.

3) "Department" means the Illinois Department of Public Aid.

4) "Fund" means the Hospital Provider Fund.

5) "Hospital" means an institution, place, building, or agency located in this State that is subject to licensure by the Illinois Department of Public Health under the Hospital Licensing Act, whether public or private and whether organized for profit or not-for-profit.

6) "Hospital provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

7) "Intergovernmental transfer payment/Interagency Agreement" means the payments established under Section 15-3 of P.A. 87-861, as amended by P.A. 88-85, ~~and~~ P.A. 88-88 and P.A. 88-554, and includes without limitation payments payable under that Section for July, August and September of 1992.

8) "Maximum Section 5A-2 Contribution" is the total amount of tax imposed by Section 5A-2 of Public Act 88-88, as amended by Public Act 89-21, in the previous State fiscal year ~~1994~~ on providers subject to the assessment imposed by subsection (b) above; multiplied by a fraction the numerator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for the previous State fiscal year ~~1994~~ and the denominator of which is adjusted gross hospital revenues reported to the Department by providers subject to the assessment imposed by subsection (b) for the State fiscal year immediately preceding the previous State ~~fiscal~~ year ~~1993~~.



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9) "Medicare Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by Medicare, as appropriate, pursuant to agreements between the hospital and the Health Care Financing Administration.

10) "Provider's Savings Rate" effective July 1, 1994, is 1.88 percent ~~6~~ multiplied by a fraction, the numerator of which is the Maximum Section 5A-2 Contribution minus the Cigarette Tax Contribution, and the denominator of which is the Maximum Section 5A-2 Contribution. Effective July 1, 1995, the Provider's Savings Rate is 1.25 percent multiplied by the same fraction as described above.

11) "Rural hospital" means a hospital that is ~~either~~:

A) located outside a metropolitan statistical area;~~, or is~~

B) located 15 miles or less from a county that is outside a metropolitan statistical area and that is licensed to perform medical/surgical or obstetrical services and had ~~has~~ a combined approved total bed capacity of 75 or fewer beds in these two service categories as of the effective date of P.A. 88-88 (July 14, 1993), as determined by the Illinois Department of Public Health; or~~,~~

C) qualified as a rural hospital by meeting subsection (l)(11)(A) or (B) above as of July 14, 1993.

12) The Illinois Department of Public Health must have been notified in writing of any changes to a facility's bed count on or before the effective date of P.A. 88-88 (July 14, 1993). Appeals of the geographic designation of hospital provider shall be in accordance with 89 Ill. Adm. Code 148.310(m).

13) ~~12)~~ "Swing-beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

**Section 140.82 Developmentally Disabled Care Provider Fund**

a) Purpose and Contents

1) The Developmentally Disabled Care Provider Fund was created in the State Treasury upon enactment of Public Act 87-861, ~~and~~ Public Act 88-88 and Public Act 89-21. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used

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to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, ~~and~~ Public Act 88-88 and Public Act 89-21.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) below;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) All other monies received for the Fund from any other source, including interest earned thereon; and

E) All monies transferred from the Medicaid Developmentally Disabled Provider Participation Fee Trust Fund.

b) Provider Assessments

Beginning on July 1, 1993, an assessment is imposed upon each developmentally disabled care provider ~~for the State fiscal year beginning on July 1, 1993, and ending on June 30, 1995,~~ in an amount equal to six percent of its adjusted gross developmentally disabled care revenue for the prior State fiscal year. ~~Adjusted gross developmentally disabled care revenue for the fiscal year beginning on July 1, 1993, will be based upon the provider's annualized State fiscal year 1993 revenue. Adjusted gross developmentally disabled care revenue for the fiscal year beginning on July 1, 1994, will be based upon the provider's annualized State fiscal year 1994 revenue.~~ The revenue for each year will be reported on the Developmentally Disabled Care Provider Tax form to be filed by a date designated by the Department. The Department reserves the right to audit the reported data.

c) Payment of Assessment Due

1) The assessment described in subsection (b) above shall be due and payable in quarterly installments, each equalling one-fourth of the assessment for the year, on September 30, December 31, March 31, and May 31 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the due dates. Assessment payments postmarked on the due date will be considered paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) After June 30 of each State fiscal year, and on or before September 30 of the succeeding State fiscal year, every developmentally disabled care provider subject to an assessment under subsection (b) above shall file a report with the



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Department. The report shall be on a form prepared by the Department. The report shall include the adjusted gross developmentally disabled care revenue from the State fiscal year just ended and shall be utilized by the Department to calculate the assessment for the State fiscal year commencing on the preceding July 1. If a developmentally disabled care provider operates or maintains more than one developmentally disabled care facility, a separate report shall be filed for each facility. In the case of a developmentally disabled care provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the developmentally disabled care provider fails to file its report for a State fiscal year on or before the due date of the report, there shall be, unless waived by the Department for reasonable cause, added to the assessment imposed in subsection (b) above a penalty assessment equal to 25 percent % of the assessment imposed for the year.

3) Every developmentally disabled care provider subject to an assessment under subsection (b) above shall keep records and books that will permit the determination of adjusted gross developmentally disabled care revenue on a State fiscal year basis. All such books and records shall be maintained for a minimum of three years following the filing date of the assessment report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended Assessment Reports. With the exception of amended assessment reports filed in accordance with subsection (d)(5) or (6) below, an amended assessment report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual assessment amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Submission of Financial Audit Statements. All developmentally disabled care providers are required to submit a copy of all financial statements audited by an external, independent auditor to the Department within 30 days of the close of such externally performed financial audits. If the provider's year end does not coincide with the June 30th ending date for the assessment report, the provider must submit all financial audits covering the assessment report period. An amended assessment report must accompany such external financial audit statements if the data submitted on the initial assessment report changes based upon the

findings of such external financial audits and as indicated in the audited external financial statements. Penalties may be applied to the amount underpaid due to a filing error.

6) Reconsideration of Adjusted Assessment. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment was due, changes the assessment liability of a developmentally disabled care provider, the developmentally disabled care provider may request a review or reconsideration of the adjusted assessment within 30 days of the Department's notification of the change in assessment liability. Requests for reconsideration of the assessment adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

1) Cessation of business during the fiscal year in which the assessment is being paid. For a developmentally disabled care provider who ceases to conduct, operate, or maintain a facility to which the person is subject to assessment under subsection (b) above, the assessment for the State fiscal year in which the cessation occurs shall be adjusted by multiplying the assessment computed under subsection (d) above by a fraction, the numerator of which is the number of days in the year during which the provider conducts, operates, or maintains the facility and the denominator of which is 365. The person shall file a final, amended report with the Department not more than 30 calendar days after the cessation, reflecting the adjustment, and shall pay with the final report the assessment for the year as so adjusted, to the extent not previously paid.

2) Commencing of business during the fiscal year in which the assessment is being paid. A developmentally disabled care provider who commences conducting, operating, or maintaining a facility of which the person is subject to assessment under subsection (b) above, shall file an initial return for the State fiscal year in which the commencement occurs within 30 calendar days thereafter and shall pay the assessment under subsection (d) above as computed by the Department in equal installments on the due date of the initial assessment determination and on the regular installment due dates for the State fiscal year occuring after the due date of the initial assessment determination. In determining the annual assessment amount for the provider the Department shall develop hypothetical annualized revenue projections based upon geographic location, facility size and patient case mix. The assessment determination made by the Department is final.

3) Partial Fiscal Year Operation Adjustment. For a developmentally disabled care provider that did not conduct, operate, or maintain a facility throughout the entire fiscal year reporting period, the assessment for the following State fiscal year shall be annualized based on the provider's actual developmentally disabled care revenue for the portion of the reporting period the facility was operational (dividing adjusted developmentally disabled care revenue by the number of days the facility was in operation and then multiplying that amount by 365). Developmentally disabled care revenue realized by a prior provider from the same facility during the fiscal year shall be used in the annualization equation, if available.



4) Changes in Ownership and/or Operators. The full quarterly assessment must be paid on the designated due dates regardless of changes in ownership or operators. Liability for the payment of the assessment amount (including past due assessments and any interest or penalties that may have accrued against the amount) rests on the developmentally disabled care provider currently operating or maintaining the developmentally disabled care facility regardless if these amount were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties

1) Any facility that fails to pay the full amount of an installment when due shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent ~~5%~~ of the amount of the installment not paid on or before the due date, plus five percent ~~5%~~ of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100 percent ~~%~~ of the installment amount not paid on or before the due date.

2) Within 45 days from the due date, the Department may begin recovery actions against delinquent facilities participating in the Medicaid Program. Payments may be withheld from the facility until the entire assessment, including any penalties, is satisfied, or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if the facility fails to comply with an agreement the Department reserves the right to recover any outstanding provider assessment, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with Department rules contained in 89 Ill. Adm. ~~Illinois--Admin.~~ Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment process. Recoupment proceedings against

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the same facility two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the facility does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months of the assessment due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Facilities
The Director may establish delayed payment of assessments and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to State cash flow; or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the assessment.

h) Delayed Payment - Individual Facilities
In addition to the provisions of subsection (g) above, the Director may delay assessments for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the assessment was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provision shall be made only to qualified facilities who meet all of the following requirements:

A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and which result in extensive financial problems to a



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facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85 percent or more of their residents must be eligible for public assistance.

ii) a government-owned facility, which meets the cash flow criteria under subsection (h)(1)(A)(ii) above.

iii) a provider who has filed for Chapter 11 bankruptcy, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

C) the facility must file a delay of payment request as defined in subsection (h)(3)(A) below, and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of assessment payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the assessment payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets have been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the assessment payment for dividends, salaries in excess of those allowable under Section 140.541 or payments for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow assessment funds through a cash flow bond pool or financial institution such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

ii) specific dates on which payments must be received and

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the amount of payment which must be received on each specific date described;

iii) the interest or a statement of interest waiver as described in subsection (h)(5) that shall be due from the facility as a result of institution of the delayed payment provisions;

iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;

v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signature's knowledge; and

vi) such other terms and conditions that may be required by the Department.

2) A facility which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests ~~as follows: delayed payment requests for installments due on September 30 of the year must be received on or before September 10 of the year; and delayed payment requests for installments due on December 31 of the year must be received on or before December 10 of the year; delayed payment requests for installments due on March 31 of the year must be received on or before March 11 of the year; delayed payment requests for installments due on May 31 of the year must be received on or before May 10 of the year~~. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests postmarked no later than the date of the telefax. The request must include:



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i) an explanation of the circumstances creating the need for the delayed payment provisions;

ii) supportive documentation to substantiate the emergency nature of the request and risk of irreparable harm to the clients; and

iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the assessment due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) of this Section may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above, is 1.5 or less and the facility meets the criteria in (h)(1)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a facility that has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration; enforcement provisions

Pursuant to Section 5C-6 of P.A. 86-861, to the extent practicable,

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the Department shall administer and enforce P.A. 86-861, ~~and~~ P.A. 88-88 and P.A. 89-21, and collect the assessments, interest, and penalty assessments imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in P.A. 89-21 ~~88-88~~ shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment impose before the effective date of P.A. 89-21 ~~88-88~~.

k) Definitions

1) "Adjusted gross developmentally disabled care revenue" means the developmentally disabled care provider's total revenue for inpatient residential services, less contractual allowances and discounts on patients' accounts, but does not include non-patient revenue from sources such as contributions, donations or bequests, investments, day training services, television and telephone service, rental of facility space, or sheltered care revenue. Adjusted gross developmentally disabled care revenue must be reported on an accrual basis for the tax reporting period. All patient revenue accrued during the tax reporting period must be included even though reimbursement may occur after the tax reporting period. Patient revenue must be reported on a basis that is consistent with methods used on the facility's last two cost reports.

2) "Contractual Allowance" means the difference between charges at established rates and the amount estimated to be paid by third party payors or patients, as appropriate, pursuant to agreements/contracts with the developmentally disabled care provider; courtesy and policy discounts provided to employees, medical staff and clergy; and charity care, but "contractual allowance" does not mean any Provider Participation fees/taxes paid to the Illinois Department of Public Aid.

3) "Department" means the Illinois Department of Public Aid.

4) "Developmentally disabled care facility" means an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act, whether public or private and whether organized for profit or not-for-profit, but shall not include any facility operated by the State.

5) "Developmentally disabled care provider" means a person conducting, operating, or maintaining a developmentally disabled care facility. For this purpose, "person" means any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian or other representative appointed by order of any court.

6) "Facility" means all intermediate care facilities as defined under "Developmentally disabled care facility" above.

7) "Fund" means the Developmentally Disabled Care Provider Fund.

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

**Section 140.84 Long Term Care Provider Fund**

a) Purpose and Contents

1) The Long Term Care Provider Fund was created in the State Treasury upon enactment of Public Act 87-861, ~~and~~ Public Act 88-88 and Public Act 89-21. Interest earned by the Fund shall be credited to the Fund. The Fund shall not be used to replace any funds appropriated to the Medicaid program by the General Assembly.

2) The Fund is created for the purpose of receiving and disbursing monies in accordance with this Section and Public Act 87-861, ~~and~~ Public Act 88-88 and Public Act 89-21.

3) The Fund shall consist of:

A) All monies collected or received by the Department under subsection (b) below;

B) All federal matching funds received by the Department as a result of expenditures made by the Department that are attributable to monies deposited in the Fund;

C) Any interest or penalty levied in conjunction with the administration of the Fund;

D) All other monies received for the Fund from any other source, including interest earned thereon;

E) All monies transferred from the Medicaid Long Term Care Provider Participation Fee Trust Fund; and

F) All monies transferred from the Tobacco Products Tax Act.

b) License Fee

Beginning on July 1, 1993, a nursing home license fee is imposed upon each nursing home provider ~~for the State fiscal year beginning on July 1, 1993, and ending on June 30, 1995,~~ in an amount equal to $1.50 for each licensed nursing bed day for the calendar quarter in which the payment is due. All nursing ~~home~~ beds subject to licensure under the Nursing Home Care Act or the Hospital Licensing Act, with the exception of swing-beds, as defined in subsection (k)(8) of this Section will be used to calculate the licensed nursing bed days for each quarter. This license fee shall not be billed or passed on to any resident of a nursing home operated by the nursing home providers. Changes in the number of licensed nursing beds will be reported to the Department quarterly, as described in subsection (d)(1) below. The Department reserves the right to audit the reported data.

c) Payment of License Fee Due

1) The license fee described in subsection (b) above shall be due and payable in quarterly installments, on September 10, December



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10, March 10, and June 10 of the year, modified to accommodate weekends and holidays. Providers will be notified, in writing, of the quarterly due dates. License fee payments postmarked on the due date will be considered as paid on time.

2) All payments received by the Department shall be credited first to unpaid installment amounts (rather than to penalty or interest), beginning with the most delinquent installments.

3) County nursing homes directed and maintained pursuant to Section 5-1005 of the Counties Code may meet their license fee obligation by the county government certifying to the Department that county expenditures have been obligated for the operation of the county nursing home in an amount at least equal to the amount of the license fee. County governments wishing to provide such certification must:

A) Sign a certification form certifying that the funds represent expenditures eligible for federal financial participation under Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.), and that these funds are not federal funds, or are federal funds authorized by federal law to be used to match other federal funds;

B) Submit the certification document to the Department once a year along with a copy of that portion of the county budget showing the funds appropriated for the operation of the county nursing home. These documents must be submitted within 30 days after the final approval of the county budget. The county budget and/or budgets covering the State fiscal year of July 1, 1993, through June 30, 1995, must be submitted by a date designated by the Department;

C) Submit the monthly claim form in the amount of the rate established by the Department minus any third party liability amount. This amount will be reduced by an amount determined by the amount certified and the number of months remaining in the fiscal year, prior to payment because a certification statement was provided in lieu of an actual license fee payment; and

D) Make records available upon request to the Department and/or the United States Department of Health and Human Services pertaining to the certification of county funds.

d) Reporting Requirements, Penalty, and Maintenance of Records

1) On or before the due dates described in subsection (c)(1), each nursing home provider subject to a license fee under subsection (b) of this Section shall file a report with the Department reflecting any changes in the number of licensed nursing beds occurring during the reporting quarter. The report shall be on a form prepared by the Department. The changes will be reported quarterly and shall be submitted with the revised quarterly license fee payment. For the purpose of calculating the license fee described in subsection (b) above, all changes in licensed



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nursing beds will be effective upon approval of the change by the Illinois Department of Public Health. Documentation showing the change in licensed nursing beds, and the date the change was approved by the Illinois Department of Public Health, must be submitted to the Department of Public Aid with the licensed nursing bed change form. If a nursing home provider operates or maintains more than one nursing home, a separate report shall be filed for each facility. In the case of a nursing home provider existing as a corporation or legal entity other than an individual, the report filed by it shall be signed by its president, vice-president, secretary, or treasurer or by its properly authorized agent.

2) If the nursing home provider fails to file its report for a State fiscal year on or before the due date of the report, there shall, unless waived by the Department for reasonable cause, be added to the license fee imposed in subsection (b) above a penalty fee equal to 25 percent % of the license fee imposed for the year.

3) Every nursing home provider subject to a license fee under subsection (b) above shall keep records and books that will permit the determination of licensed nursing bed days on a quarterly basis. All such books and records shall be maintained for a minimum of three years following the filing date of the license fee report and shall, at all times during business hours of the day, be subject to inspection by the Department or its duly authorized agents and employees.

4) Amended License Fee Reports. With the exception of amended license fee reports filed in accordance with subsection (d)(5) below, an amended license fee report must be filed within 30 calendar days after the original report due date. The amended report must be accompanied by a letter identifying the changes and the justification for the amended report. The provider will be advised of any adjustments to the original annual license fee amount through a written notification from the Department. Penalties may be applied to the amount underpaid due to a filing error.

5) Reconsideration of Adjusted License Fee. If the Department, through an audit conducted by the Department or its agent within three years after the end of the fiscal year in which the assessment/license fee was due, changes the license fee liability of a nursing home provider, the nursing home provider may request a review or reconsideration of the adjusted license fee within 30 days of the Department's notification of the change in license fee liability. Requests for reconsideration of the license fee adjustment shall not be considered if such requests are not postmarked on or before the end of the 30 day review period. Penalties may be applied to the amount underpaid due to a filing error.

e) Procedure for Partial Year Reporting/Operating Adjustments

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1) Cessation of business during the quarter in which the license fee is being paid and the closure date has been set. A nursing home provider who ceases to conduct, operate, or maintain a facility to which the person is subject to the license fee imposed under subsection (b) above, and for which the closure date for the facility has been set, shall file a final report with the Department on or before the due date for the quarter in which the closure is to occur. The report will reflect the adjusted number of days the facility is open during the reporting quarter, and shall be submitted with the final quarterly payment. Example: A facility is set to close on September 24. On or before the due date ~~of September 10,~~ for the reporting quarter of July 1 through September 30, the facility will submit a final report reflecting 86 days of the operation (July 1 through September 24) and the corresponding quarterly license fee payment.
2) Cessation of business after the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) above, and for which closure occurs after the due date for the reporting quarter, but prior to the last day of the reporting quarter, shall file an amended final report with the Department within 30 days after the closure date. The amended report will reflect the number of days the facility was operated during the reporting quarter and the revised license fee amount. Upon verifying the data submitted on the amended report, the Department will issue a refund for the amount overpaid. Example: On December 10 a facility pays the license fee for 92 days covering the reporting quarter of October 1 through December 31. The facility closes December 27. An amended report reflecting 88 days, the actual number of days the facility was operational during the quarter (October 1 through December 27) must be filed with the Department.
3) Cessation of business prior to the quarterly due date. A nursing home provider who ceases to conduct, operate, or maintain a facility for which the person is subject to the license fee imposed under subsection (b) above, and for which closure occurs prior to the due date for the reporting quarter, shall file a final report with the Department within 30 days after the closure date. The final report will reflect the number of days the facility was operational during the reporting during the quarter and the corresponding final license fee amount. Closure dates will be verified with the Department of Public Health, and if necessary adjustments will be made to the final license fee due. Example: Facility closes on January 17. On or before February 17, the facility must file a final report for the reporting quarter of January 1 through March 31. The report would reflect 17 days of operation (January 1 through January 17) during the quarter and must be accompanied by the final license fee payment



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for the facility.
4) Commencing of business during the fiscal year in which the license fee is being paid. A nursing home provider who commences conducting, operating, or maintaining a facility for which the person is subject to the license fee imposed under subsection (b) above, shall file an initial report for the reporting quarter in which the commencement occurs within 30 calendar days thereafter and shall pay the license fee under subsection (d) above.
5) Change in ownership and/or operators. The full quarterly assessment/license fee must be paid on the designated due date regardless of changes in ownership operators. Liability for the payment of the assessment/license fee amount (including past due assessment/license fees and any interest or penalties that may have accrued against the amount) rests on the nursing home provider currently operating or maintaining the nursing facility regardless if these amounts were incurred by the current owner or were incurred by previous owners. Collection of delinquent assessment/license fees from previous providers will be made against the current provider. Failure of the current provider to pay any outstanding assessment/license fee liabilities incurred by previous providers shall result in the application of penalties described in subsection (f)(1) of this Section.

f) Penalties
1) Any nursing home provider that fails to pay the full amount of an installment when due, or fails to report a change in licensed nursing beds approved by the Department of Public Health prior to the due date of installment, shall be charged, unless waived by the Department for reasonable cause, a penalty equal to five percent ~~5%~~ of the amount of the installment not paid on or before the due date, plus five percent ~~5%~~ of the portion thereof remaining unpaid on the last day of each month thereafter, not to exceed 100 percent ~~%~~ of the installment amount not paid on or before the due date.
2) Within 45 days from the due date, the Department may begin recovery actions against delinquent nursing home providers participating in the Medicaid Program. Payments may be withheld from the provider until the entire license fee, including any penalties, is satisfied or until a reasonable repayment schedule has been approved by the Department. If a reasonable agreement cannot be reached, or if a provider fails to comply with an agreement, the Department reserves the right to recover any outstanding license fee, interest and penalty by recouping the amount or a portion thereof from the provider's future payments from the Department. The provider may appeal this recoupment in accordance with the Department rules contained in 89 Ill. Adm. Code 104. The Department has the right to continue recoupment during the appeal process. Penalties pursuant to subsection (f)(1) above will continue to accrue during the recoupment

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process. Recoupment proceedings against the same nursing home provider two times in a fiscal year may be cause for termination from the Program. Failure by the Department to initiate recoupment activities within 45 days shall not reduce the provider's liabilities nor shall it preclude the Department from taking action at a later date.

3) If the nursing home provider does not participate in the Medicaid Program, or is no longer doing business with the Department, or the Department cannot recover the full amount due through the claims processing system, within three months after the fee due date, the Department may begin legal action to recover the monies, including penalties and interest owed, plus court costs.

g) Delayed Payment - Groups of Facilities
The Director may establish delayed payment of fees and/or waive the payment of interest and penalties for groups of facilities when:

1) the State delays payments to facilities due to problems related to State cash flow;~~,~~ or

2) a cash flow bond pool's or any other group financing plans' requests from providers for loans are in excess of its scheduled proceeds such that a significant number of facilities will be unable to obtain a loan to pay the license fee.

h) Delayed Payment - Individual Facilities
In addition to the provisions of subsection (g) above, the Director may delay license fees for individual facilities that are unable to make timely payments under this Section due to financial difficulties. No delayed payment arrangements shall extend beyond the last business day of the calendar quarter following the quarter in which the license fee was to have been received by the Department as described in subsection (c) above.

1) Criteria. Delayed payment provisions may be instituted only under extraordinary circumstances. Delayed payment provisions shall be made only to qualified facilities who meet all of the following requirements:

A) the facility has experienced an emergency which necessitates institution of delayed payment provisions. Emergency in this instance is defined as a circumstance under which institution of the payment and penalty provisions described in subsections (c)(1), (c)(2), (f)(1), (f)(2) and (f)(3) above would impose severe and irreparable harm to the clients served. Circumstances which may create such emergencies include, but are not limited to, the following:

i) Department system errors (either automated system or clerical) which have precluded payments, or which have caused erroneous payments such that the facility's ability to provide further services to clients is severely impaired;

ii) cash flow problems encountered by a facility which are unrelated to Department technical system problems and



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which result in extensive financial problems to a facility adversely impacting on its ability to serve its clients.

B) the facility serves a significant number of clients under the Medical Assistance Program. Significant in this instance means:

i) 85 percent or more of their residents must be eligible for public assistance.

ii) a government-owned facility, which meets the cash flow criterion under subsection (h)(1)(A)(ii) above.

iii) a provider who has filed for Chapter 11 bankruptcy, which meets cash flow criterion under subsection (h)(1)(A)(ii).

C) the facility must file a delay of payment request as defined under subsection (h)(3)(A) and the request must include a Cash Position Statement which is based upon current assets, current liabilities and other data for a date which is less than 60 days prior to the date of filing. Any liabilities payable to owners or related parties must not be reported as current liabilities on the Cash Position Statement. A deferral of license fee payments will be denied if any of the following criteria are met:

i) the ratio of current assets divided by current liabilities is greater than 2.0;

ii) cash, short term investments and long term investments equal or exceed the total of accrued wages payable and the license fee payment. Long term investments which are unavailable for expenditure for current operations due to donor restrictions or contractual requirements will not be used in this calculation;

iii) cash or other assets have been distributed during the previous 90 days to owners or related parties in an amount equal to or exceeding the license fee payment for dividends, salaries in excess of those allowable under Section 140.541 or payment for purchase of goods or services in excess of cost as defined in Section 140.537.

D) the facility, with the exception of government owned facilities, must show evidence of denial of an application to borrow license fee funds through a cash flow bond pool or financial institutions such as a commercial bank. The denial must be 90 days old or less.

E) the facility must sign an agreement with the Department which specifies the terms and conditions of the delayed payment provisions. The agreement shall contain the following provisions:

i) specific reason(s) for institution of the delayed payment provisions;

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ii) specific dates on which payments must be received and the amount of payment which must be received on each specific date described;
iii) the interest or a statement of interest waiver as described in subsection (h)(5) below that shall be due from the facility as a result of institution of the delayed payment provisions;
iv) a certification stating that, should the entity be sold, the new owners will be made aware of the liability and any agreement selling the entity will include provisions that the new owners will assume responsibility for repaying the debt to the Department according to the original agreement;
v) a certification stating that all information submitted to the Department in support of the delayed payment request is true and accurate to the best of the signature's knowledge; and
vi) such other terms and conditions that may be required by the Department.

2) A facility which does not meet the above criteria may request a delayed payment schedule and/or the waiver of interest and penalties. The Director may approve the request, notwithstanding the facility not meeting the above criteria, upon a sufficient showing of financial difficulties and good cause by the facility. If the request for a delayed payment schedule and/or waiver of interest and penalties is approved, all other conditions of this subsection (h) shall apply.

3) Approval Process

A) In order to receive consideration for delayed payment provisions, facilities must submit their request in writing (telefax requests are acceptable) to the Bureau of Program and Reimbursement Analysis. The request must be received by the due date designated by the Department. Providers will be notified, in writing, of the due dates for submitting delay of payment requests ~~as follows: delayed payment requests for installments due on September 10 of the year must be received on or before August 20 of the year; delayed payment requests for installments due on December 10 of the year must be received on or before November 22 of the year; delayed payment requests for installments due on March 10 of the year must be received on or before February 10 of the year; and delayed payment requests for installments due on June 10 of the year must be received on or before May 20 of the year~~. Requests must be complete and contain all required information before they are considered to have met the time requirements for filing a delayed payment request. All telefax requests must be followed up with original written requests, ~~by certified mail~~ postmarked no later than



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the date of the telefax. The request must include:
i) an explanation of the circumstances creating the need for the delayed payment provisions;
ii) supportive documentation to substantiate the emergency nature of the request including a cash position statement as defined in subsection (h)(1)(C) a denial of application to borrow the license fee as defined in subsection (h)(1)(D) and an explanation risk of irreparable harm to the clients; and
iii) specification of the specific arrangements requested by the facility.

B) The facility shall be notified by the Department, in writing prior to the license fee due date, of the Department's decision with regard to the request for institution of delayed payment provisions. An agreement shall be issued to the facility for all approved requests. The agreement must be signed by the administrator, owner or other authorized representative and be received by the Department prior to the first scheduled payment date listed in such agreement.

4) Waiver of Penalties. The penalties described in subsections (f)(1) and (f)(2) may be waived upon approval of the facility's request for institution of delayed payment provisions. In the event a facility's request for institution of delayed payment provisions is approved and the Department has received the signed agreement in accordance with subsection (h)(3)(B) above, such penalties shall be permanently waived for the subject quarter unless the facility fails to meet all of the terms and conditions of the agreement. In the event the facility fails to meet all of the terms and conditions of the agreement, the agreement shall be considered null and void and such penalties shall be fully reinstated.

5) Interest. The delayed payments shall include interest at a rate not to exceed the State of Illinois borrowing rate. The applicable interest rate shall be identified in the agreement described in subsection (h)(1)(E) above. The interest may be waived by the Director if the facility's current ratio, as described in subsection (h)(1)(C) above, is 1.5 or less and the facility meets the criteria in subsections (h)(1)(A) and (B). Any such waivers granted shall be expressly identified in the agreement described in subsection (h)(1)(E) above.

6) Subsequent Delayed Payment Arrangements. Once a facility has requested and received approval for delayed payment arrangements, the facility shall not receive approval for subsequent delayed payment arrangements until such time as the terms and conditions of any current delayed payment agreement have been satisfied or unless the provider is in full compliance with the terms of the current delay of payment agreement. The waiver of penalties described in subsection (h)(4) shall not apply to a facility that

has not satisfied the terms and conditions of any current delayed payment agreement.

i) Administration ~~,~~ enforcement provisions
Pursuant to Section 5B-7 of P.A. 87-861, to the extent practicable, the Department shall administer and enforce P.A. 86-861, ~~and~~ P.A. 88-88 and P.A. 89-21, and collect the license fees, interest, and penalty fees imposed under the law, using procedures employed in its administration of this Code generally and, as it deems appropriate, in a manner similar to that in which the Department of Revenue administers and collects the retailers' occupation tax under the Retailers' Occupation Tax Act ("ROTA").

j) Nothing in P.A. 89-21 ~~88-88~~ shall be construed to prevent the Department from collecting all amounts due under this Section pursuant to an assessment imposed before the effective date of P.A. 89-21 ~~88-88~~.

k) Definitions
As used in this Section, unless the context requires otherwise:

1) "Department" means the Illinois Department of Public Aid.

2) "Fund" means the Long-Term Care Provider Fund.

3) "Hospital Provider" means a person licensed by the Department of Public Health to conduct, operate, or maintain a hospital, regardless of whether the person is a Medicaid provider. For purposes of this definition, "person" means any political subdivision of the State, municipal corporation, individual firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

4) "Licensed nursing bed days" means, with respect to a nursing home provider, the sum for all nursing ~~home~~ beds, with the exception of swing-beds, as described in subsection (k)(8) of this Section, of the number of days during a calendar quarter on which each bed is covered by a license issued to that provider under the Nursing Home Care Act or the Hospital Licensing Act.

5) "Nursing home" means a skilled nursing or intermediate long-term care facility, whether public or private and whether organized for profit or not-for-profit, that is subject to licensure by the Illinois Department of Public Health under the Nursing Home Care Act, including a county nursing home directed and maintained under Section 5-1005 of the Counties Code; and a part of a hospital in which skilled or intermediate long-term care services within the meaning of Title XVIII or XIX of the Social Security Act. However, the term "nursing home" does not include a facility operated solely as an intermediate care facility for the mentally retarded within the meaning of Title XIX of the Social Security Act.

6) "Nursing home provider" means a person licensed by the Department of Public Health to operate and maintain a skilled nursing or



intermediate long-term care facility which charges its residents, a third party payor, Medicaid, of Medicare for skilled nursing or intermediate long-term care services; or a hospital provider that provides skilled or intermediate long-term care service within the meaning of Title XVIII or XIX of the Social Security Act.

7) "Person" means, in addition to natural persons, any political subdivision of the State, municipal corporation, individual, firm, partnership, corporation, company, limited liability company, association, joint stock association, or trust, or a receiver, executor, trustee, guardian, or other representative appointed by order of any court.

8) "Swing-beds" means those beds for which a hospital provider has been granted an approval from the federal Health Care Financing Administration to provide post-hospital extended care services (42 CFR 409.30, October 1, 1991) and be reimbursed as a swing-bed hospital (42 CFR 413.114, October 1, 1991).

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

SUBPART D: PAYMENT FOR NON-INSTITUTIONAL SERVICES

**Section 140.440 Pharmacy Services**

a) Payment shall be made only to pharmacies.

b) The following conditions apply to pharmacy participation:

1) The pharmacy must hold a current Drug Enforcement Administration (DEA) registration issued by the United States Drug Enforcement Administration (see 21 CFR 1301 et seq.), as well as a current controlled substances license issued by the Illinois Department of Professional Regulation (see Controlled Substances Act ~~(Ill. Rev. Stat. 1991, ch. 56 1/2, par. 1301 et seq.)~~ [720 ILCS 570]) prior to enrolling with the Department.

2) Licensed Pharmacy Requirements

A) A licensed pharmacy located in and/or administratively associated with a group practice or long-term facility must:

i) provide the same scope of general pharmacy and professional services as a pharmacy not so affiliated; and

ii) be retail in nature, open and accessible to the general public.

B) The pharmacy shall not limit prescriptions filled to those written by practitioners connected with the group or facility for persons receiving care or services from the group or facility.

3) A hospital pharmacy which provides pharmaceutical services and supplies for inpatients, outpatient clinic patients and emergency

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room patients of the hospital may not enroll as a participating pharmacy unless licensed to provide pharmaceutical services to the general public (Division 5 license).

c) The Department shall pay for the dispensing of pharmacy items, subject to the provisions of subsection (d) below and Section 140.443, which are prescribed by a physician, dentist or podiatrist within the scope of their professional practice.

d) Beginning with drugs dispensed on or after April 1, 1991, Department coverage shall be limited to those drug manufacturers having rebate agreements in effect as provided under Section 1927 of Title XIX of the Social Security Act (42 U.S.C. 1396s). The Department shall provide all interested parties with an updated list of drug manufacturers having rebate agreements in effect.

e) The Department may require approval for the reimbursement of any drug except as provided in Section 140.442. When reviewing requests for prior authorization, approval decisions shall be medically based. The Department's electronic claims processing system shall be the mechanism for identification of whether a prescribed drug requires prior authorization to dispensing pharmacists. A printed listing of prescribed drugs available without prior approval shall be provided to other interested parties upon request.

f) An approved request does not guarantee payment. The recipient for whom the services/items are approved must be eligible at the time they are provided. In addition, a valid, current prescription for the requested medication must be on file and maintained by the pharmacy in accordance with the Pharmacy Practice Act of 1987 [225 ILCS 85].

g) For purposes of Sections 140.440 through 140.448, pertaining to reimbursement for drugs, the following definitions apply:

1) Nursing facility means any facility which provides medical group care services as defined in Section 140.500.

2) Generic drug means those legend drugs which are multiple source drugs marketed or sold by two or more labelers, marketed or sold by the same labeler under two or more different proprietary names or marketed both under a proprietary name and without such a name.

3) Brand name drug means single-source innovator drugs and innovator multiple-source drugs when prior authorization has been obtained for reimbursing the innovator product.

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

**Section 140.443 Filing of Prescriptions**

a) The prescription form (or the official form required by law for the prescribing of controlled substances) must contain the following information at a minimum:

1) Recipient's name;



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2) Date;
3) Name of pharmacy item being prescribed;
4) Form and strength or potency of drug (or size of non-drug item);
5) Quantity;
6) Directions for use;
7) Refill directions;
8) Legible signature of practitioner in ink; and
9) Drug Enforcement Administration (DEA) Number or the Social Security Number (for those practitioners who do not have a DEA Number).

b) Pharmacies shall not accept blank, presigned prescription forms.

c) If a drug is available by generic name and the identical drug is prescribed by trade name, payment will be based on cost of the generic product unless prior authorization has been obtained for reimbursement based upon the innovator product.

d) The Department shall not pay for ~~quantities of dispensed items in excess of the maximum quantities designated for such items in the Drug Manual~~ dispensed items in excess of the maximum quantity established by the Department, unless ~~it has given~~ prior approval has been granted to dispense an amount in excess of the maximum. The ~~If the Drug Manual does not specify a maximum quantity, the~~ Department shall pay for no more than one month's supply of the item dispensed.

e) The Department shall pay for refills only if the prescribing practitioner authorized refills on the original prescription in accordance with State law.

f) Pharmacies may use a unit dose system in the dispensing of drugs when such a system is in compliance with all applicable State and Federal laws. The total quantity dispensed on one prescription cannot exceed the quantity prescribed or the maximum allowable quantity.

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

**Section 140.444 Compounded Prescriptions**

a) Pharmacy charges for compounded prescriptions shall be billed at the per ingredient charge to the general public.

b) Reimbursement will be at the lower of the pharmacy's charge or the Department's maximum for each ingredient.

~~a) The Department shall pay for compound prescriptions the lower of:~~

~~1) the prevailing charge of the pharmacy to the general public for the item; or~~

~~2) the total of ingredient cost (a minimum charge of $0.10 will be recognized); gelatin capsule cost (when applicable); the current professional fee established by the Department; and a compounding fee.~~

~~b) The compounding fee is:~~

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~~1) Capsules up to 30 capsules---$2.00~~
~~31 to 60 capsules---$3.50~~
~~61 to 100 capsules--$5.00~~
~~2) Ointments and bulk powders up to 120 grams--$1.80~~
~~over 120 grams---$2.20~~
~~3) Solids with liquids-----$1.00~~
~~4) Volumetric liquids (liquids only)---no compounding fee~~

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

**Section 140.445 Legend Prescription Items (Not Compounded)**

a) For legend drugs ~~For items for which the Drug Manual (see Section 140.72) establishes a maximum price~~, the Department shall pay the lower of:
   1) the pharmacy's prevailing charge to the general public; ~~,~~ or
   2) the Department's ~~listed~~ maximum price plus the established dispensing ~~professional~~ fee.

b) For generic drugs, the Department's maximum price is calculated as the lower of ~~For items for which the Drug Manual does not establish a maximum price, the Department shall pay the lower of~~:
   1) the pharmacy's prevailing charge to the general public; ~~,~~ or
   2) the average wholesale price minus 12 percent ~~the following percentage~~ plus the established dispensing ~~professional~~ fee; or~~:~~

| ~~Percentage~~ | ~~Effective Date~~ |
|---|---|
| ~~7.5~~ | ~~07/01/88~~ |
| ~~10.0~~ | ~~07/01/89~~ |

   3) the Federal Upper Limit for drugs that have been evaluated as therapeutically equivalent in the Food and Drug Administration's publication entitled Approved Drug Products with Therapeutic Equivalence Evaluations, plus the established dispensing fee; or
   4) the State Upper Limit for drugs listed in the Illinois Formulary for the Drug Product Selection Program and not having an established Federal Upper Limit at the time of listing plus the established dispensing fee.

c) For brand name drugs, the Department's maximum price is calculated as the average wholesale price minus ten percent plus the established dispensing fee.

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

**Section 140.446 Over-the-Counter Items**

For those over-the-counter ~~"over the counter"~~ items which are covered, the



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Department shall pay the lower of: ~~the lesser of the charges or the acquisition cost plus a mark up established by the Department.~~
   1) the prevailing charge to the general public; or
   2) the wholesale acquisition cost, plus the percentage established by the Department for over-the-counter items.

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

**Section 140.447 Reimbursement**

a) The calculation of average wholesale price in the determination of the Department's maximum price (Section 140.445(b)(2)) is made using the standard package size. ~~The Department's maximum reimbursement level is based on the average wholesale price minus the percentage for RX items (items requiring a prescription under federal or state law) not otherwise listed on the Health Care Financing Administration Maximum Acquisition Cost list (as set forth in subsection 140.445(b)(2)).~~

b) If a pharmacy gives discounts to the general public, it must provide the same to Public Aid recipients. If discounts are allowed only to a specific group of people, they shall be extended to a recipient if he is a member of the special discount group. Public Aid recipients can constitute a special group and receive a discount, but they cannot be excluded from a discount group just because they are recipients.

c) The Department will require pharmacies to complete hard copy (paper) claim forms for pharmacy services and attach a Prescribing Practitioner Name Identification Form. A separate hard copy (paper) claim form and Practitioner Name Identification Form is to be required for each recipient and prescribing practitioner. ~~The Department does not recognize additional costs which may be incurred by a pharmacy through use of a unit dose system of dispensing or the purchase of convenience packaged items.~~

d) The Department will authorize an exception for pharmacies, to the requirements of Section 140.447(c), by allowing pharmacy claims to be submitted with the prescribing practitioner's DEA number, Department Medical Assistance Program participating provider identification number or Social Security Number.

(Source: Amended at 19 Ill. Reg. 16677, effective NOV 28 1995)

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENTS

1) Heading of the Part: Alternate Fuel Systems for School Buses

2) Code Citation: 92 Ill. Adm. Code 449

3) Section Numbers: Adopted Action:
449.20 Amend

4) Statutory Authority: Implementing and authorized by Section 12-812.1 of the Illinois Vehicle Equipment Law [625 ILCS 5/12-812.1].

5) Effective Date of Rulemaking: December 1, 1995

6) Does this rulemaking contain an automatic repeal date? No

7) Does this rulemaking contain incorporations by reference? No

8) Date Filed in Agency's Principal Office: December 1, 1995

9) Notice of Proposal Published in Illinois Register:

July 21, 1995, 19 Ill. Reg. 10443

10) Has JCAR issued a Statement of Objections to these rules? No

11) Difference(s) between proposal and final version:

The Department corrected the spelling of the word "Adopted" in the Main Source Note.

The Department reworked Section 449.20(a) and (b) in response to JCAR suggestions.

12) Have all the changes agreed upon by the agency and JCAR been made as indicated in the agreement letter issued by JCAR? Yes

13) Will this rulemaking replace an emergency rule currently in effect? No

14) Are there any amendments pending on this Part? No

15) Summary and Purpose of Rulemaking:

This Part governs the use of liquefied petroleum gases and compressed natural gas as propellant fuel in school buses. The installation, maintenance and opeartion of such fuel systems are covered by this Part. This rulemaking adds a grandfather clause for alternately fueled school buses which were in existence before February 26, 1990.

16) Information and questions regarding this adopted amendment shall be



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directed to:

Name: Ms. Cathy Allen
Address: Regulations Unit
Department of Transportation
Division of Traffic Safety
P.O. Box 19212
Springfield, IL 62794-9212
Telephone: (217) 785-1135

The full text of the Adopted Amendment begins on the next page:

DEPARTMENT OF TRANSPORTATION

NOTICE OF ADOPTED AMENDMENTS

TITLE 92: TRANSPORTATION
CHAPTER I: DEPARTMENT OF TRANSPORTATION
SUBCHAPTER e: TRAFFIC SAFETY (EXCEPT HAZARDOUS MATERIALS)

PART 449
ALTERNATE FUEL SYSTEMS FOR SCHOOL BUSES

Section
449.10 Purpose and Scope
449.20 Application
449.30 Installation, Maintenance and Operation
449.40 Container Installation
449.50 Carburetion Equipment
449.60 Pipe and Hose Installation
449.70 Identification

AUTHORITY: Implementing and authorized by Section 12-812.1 of the Illinois Vehicle Equipment Law [625 ILCS 5/12-812.1].

SOURCE: Adopted at 14 Ill. Reg. 3686, effective February 26, 1990; amended at 19 Ill. Reg. 16732, effective DEC 01 1995.

**Section 449.20 Application**

a) This Part applies to any ~~person who operates a~~ school bus which is equipped to use any liquefied petroleum gas or compressed natural gas as a fuel propellant and began operation on or after February 26, 1990.

b) This Part does not apply to any school bus which was equipped to use any liquefied petroleum gas or compressed natural gas as a fuel propellant before February 26, 1990.

(Source: Amended at 19 Ill. Reg. 16732, effective DEC 01 1995)



DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

1) Heading of the Part: Services Delivered by the Department

2) Code Citation: 89 Ill. Adm. Code 302

3) Section Numbers: Emergency Action:

| | |
|---|---|
| 302.310 | Amend |
| 302.311 | Repeal |

4) Statutory Authority: 20 ILCS 505

5) Effective Date of Amendments: November 28, 1995

6) If these emergency rules are to expire before the end of the 150-day period, please specify the date on which they are to expire: Not applicable

7) Date Filed in Agency's Principal Office: November 28, 1995

8) Reason for Emergency: Public Act 89-21, which was enacted June 6, 1995, specifically amended the Illinois Administrative Procedure Act to find that the State's current financial situation constitutes an emergency and to allow State agencies to enact emergency rulemaking to implement the purposes of the Act.

9) A Complete Description of the Subjects and Issues Involved: The emergency amendments revise the eligibility requirements for adoption assistance by redefining the requirements necessary to be considered a child with special needs and by establishing a new method of calculating the amount of ongoing monthly adoption assistance, which takes into account, after eligibility has been established, the specific circumstances of the adoptive parents and the special needs of the child being adopted.

10) Are there any proposed amendments to this Part pending? Yes

| Section Numbers | Proposed Action | Illinois Register Citation |
|---|---|---|
| 302.300 | Amend | November 3, 1995 (19 Ill. Reg. 15120) |

11) Statement of Statewide Policy Objectives: These rules do not create or expand a state mandate as defined in Section 3(b) of the State Mandates Act [30 ILCS 805/3].

12) Information and questions regarding these rules shall be directed to:

Jacqueline Nottingham
Chief, Office of Rules and Procedures
Department of Children and Family Services

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

406 East Monroe, Station #222
Springfield, IL 62701-1498
(217) 524-1983 or TTY: (217) 524-3715

The full text of the emergency rules begins on the next page:



DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

TITLE 89: SOCIAL SERVICES
CHAPTER III: DEPARTMENT OF CHILDREN AND FAMILY SERVICES
SUBCHAPTER a: SERVICE DELIVERY

PART 302
SERVICES DELIVERED BY THE DEPARTMENT

SUBPART A: GENERAL PROVISIONS



SUBPART B: REPORTS OF SUSPECTED CHILD ABUSE OR NEGLECT (RECODIFIED)



SUBPART C: DEPARTMENT CHILD WELFARE SERVICES

DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS



AUTHORITY: Implementing and authorized by the Children and Family Services Act [20 ILCS 505]; Section 3-6-2(g) of the Unified Code of Corrections [730 ILCS 5/3-6-2(g)]; the Illinois Alcoholism and Dangerous Drug Dependency Act [20 ILCS 305]; the Adoption Assistance and Child Welfare Act of 1980 (42 U.S.C.A. 670 et seq.); 45 CFR 1356.40 and 1356.41; the Juvenile Court Act of 1987 [705 ILCS 405]; and the Adoption Act [750 ILCS 50].

SOURCE: Adopted and codified at 5 Ill. Reg. 13188, effective November 30, 1981; amended at 6 Ill. Reg. 15529, effective January 1, 1983; recodified at 8 Ill. Reg. 992; peremptory amendment at 8 Ill. Reg. 5373, effective April 12, 1984; amended at 8 Ill. Reg. 12143, effective July 9, 1984; amended at 9 Ill. Reg. 2467, effective March 1, 1985; amended at 9 Ill. Reg. 9104, effective June 14, 1985; amended at 9 Ill. Reg. 15820, effective November 1, 1985; amended at 10 Ill. Reg. 5557, effective April 15, 1986; amended at 11 Ill. Reg. 1390, effective January 13, 1987; amended at 11 Ill. Reg. 1551, effective January 14, 1987; amended at 11 Ill. Reg. 1829, effective January 15, 1987; recodified to 89 Ill. Adm. Code 300 at 11 Ill. Reg. 3492, Sections 302.20, 302.100, 302.110, 302.120, 302.130, 302.140, 302.150, 302.160, 302.170, 302.180, 302.190, Appendix A; amended at 13 Ill. Reg. 18847, effective November 15, 1989; amended at 14 Ill. Reg. 3438, effective March 1, 1990; amended at 14 Ill. Reg. 16430, effective September 25, 1990; amended at 14 Ill. Reg. 19010, effective November 15, 1990; amended at 16 Ill. Reg. 274, effective December 31, 1992; emergency amendment at 17 Ill. Reg. 2513, effective February 10, 1993, for a maximum of 150 days; emergency expired on July 9, 1993; amended at 17 Ill. Reg. 13438, effective July 31, 1993; amended at 19 Ill. Reg. 9107, effective June 30, 1995; amended at 19 Ill. Reg. 9485, effective July 1, 1995; emergency amendment at 19 Ill. Reg. 10746, effective July 1, 1995, for a maximum of 150 days; emergency expired November 27, 1995; emergency amendment at 19 Ill. Reg. 16735, effective November 28, 1995, for a maximum of 150 days.

SUBPART C: DEPARTMENT CHILD WELFARE SERVICES

**Section 302.310 Adoption Assistance Agreements**



DEPARTMENT OF CHILDREN AND FAMILY SERVICES

NOTICE OF EMERGENCY AMENDMENTS

**EMERGENCY**

a) Adoption assistance agreements may be provided to adoptive parents adopting children who are legally free for adoption, who are residents of Illinois and who the Department has determined have special needs because of which it is reasonable to conclude that the child cannot be adopted without providing adoption assistance. Eligibility for adoption assistance shall be determined regardless of the financial circumstances of the adoptive parents. However, the types and amounts of adoption assistance under each adoption assistance agreement shall be determined by the Department on an individual basis, taking into consideration the specific circumstances of the adoptive parents and the special care needs of the child being adopted. The types of adoption assistance that may be provided include:
   1) one-time only payments of non-recurring adoption expenses incurred by or on behalf of the adoptive parents in connection with the adoption of a special needs child, up to a maximum of $1500.00 for each adopted child;
   2) payments for physical, emotional and mental health needs not wholly payable through insurance or other public resources that are associated with or result from a medical condition(s) whose onset has been established as occurring prior to the completion of the adoption;
   3) in cases where a child also meets the eligibility requirements of subsection (d) below, ongoing monthly payments in an amount determined in each case by the Department in accordance with subsection (g) below and subject to adjustment at each annual review, but in no event greater than $25 less than the applicable licensed foster family care payment level at the time the adoption is finalized, or in the case of conditional monthly payments described in subsection (f) below, at the time the first monthly payment is made.

b) For purposes of this Section, a child shall not be considered a child with special needs unless the Department has first determined that:
   1) the child cannot or should not be returned to the home of his or her parents, as determined by:
      A) a judicial adjudication that the child is abused, neglected or dependent or other judicial determination that there is probable cause to believe that a child is abused, neglected or dependent; and
      B) a determination by the Department that the child is likely to suffer further abuse or neglect or will not be adequately cared for if returned to the parent(s); and
   2) there exists with respect to the child one or more specific factors or conditions (such as his or her ethnic background, age, or membership in a minority or sibling group, or the presence of factors such as documented medical conditions or physical, mental, or emotional handicaps), because of which the Department

reasonably concludes that such child cannot be placed with adoptive parents without providing adoption assistance; and

3) a reasonable, but unsuccessful, effort has been made to place the child with adoptive parents without providing adoption assistance and the prospective adoptive parents are either unwilling or unable to adopt the child without adoption assistance, as evidenced by a written statement from the adoptive parents. A documented search for alternative adoptive placements without adoption assistance shall be made unless the Department determines that such a search is against the best interests of the child because the child has developed significant emotional ties with the prospective adoptive parents while in their foster care.

c) Adoption assistance agreements as one-time only payments for non-recurring adoption expenses shall be provided to parents adopting a child who is determined by the Department to have special needs as provided in subsection (b) above. This includes expenses incurred by or on behalf of such parents, in connection with the adoption of a special needs child, either directly or through another public or private agency. These expenses include reasonable and necessary adoption fees, court costs, attorney fees, and other expenses that are directly related to the legal adoption of a child with special needs and that are not incurred in violation of State or Federal law. The amount of payments to be made in any specific case shall be determined by the needs of the child being adopted, and the availability of pro bono services and shall not exceed $1500.00 per adoptive child. The adoptive parents may refuse any or all payments available under this subsection (c).

d) Adoption assistance agreements for ongoing monthly payments may be provided to parents adopting a child who:

1) is determined by the Department to have special needs as provided in subsection (b) above; and

2) meets one of the following three conditions:

A) was eligible for Aid to Families with Dependent Children (AFDC) under Title IV-A of the Social Security Act at the time the adoption petition was filed;

B) was eligible for foster care maintenance payments under Title IV-E of the Social Security Act at the time the adoption petition was filed; or

C) was eligible for Supplemental Security Income (SSI) prior to finalization of the adoption; and

3) is determined by the Department to be in need of ongoing monthly assistance payments in order to provide the child with a permanent home; and

4) in all cases, other than a child determined to have special needs under subsection (b)(2) above because of a documented medical condition or a physical, mental, or emotional handicap, the child has been in the care of the Department or anther agency or person other than his or her parents pursuant to an order of the court for at least one year prior to the adoption.



e) The Department shall determine, based on the funds available for adoption assistance, whether to provide ongoing monthly payments and the amount of the payment in each individual case by taking into consideration the circumstances of the adoptive parents and the needs of the child being adopted.

f) For a child with a documented medical condition or physical, mental or emotional handicap, the ongoing monthly payments may include an amount based on the level of care needed to support the child. In cases where the determination under subsection (b)(2) is based on a diagnosis that the child will eventually require care for a documented medical condition or handicap that does not yet require treatment at the time of the adoption, no such payments based on the level of care shall be made at that time although the adoption assistance agreement may provide that such payments be initiated when the child's pre-existing condition warrants treatment or professional intervention. If such payments are commenced, the ongoing monthly payment shall in no event exceed $25 less than the amount the child would have received had the child been in foster care at the time the payments are initiated.

g) The adoption assistance agreement providing for ongoing monthly payments shall include an agreement with the adoptive parents that the amount of any ongoing monthly payments shall be reviewed at least annually and may be readjusted annually or more frequently, based on changes in the circumstances of the adoptive parents and the needs of the child being adopted, but can never exceed the maximum established when the adoption assistance agreement was finalized. The amounts of ongoing adoption assistance payments are subject to change based on changes in State or Federal law regarding adoption assistance and the availability of funds. Adoptive parents may refuse any or all payments offered by the Department.

h) A prospective adoptive family being presented with a child determined to be a special needs child shall be made aware of the availability of adoption assistance, the types of assistance available, the amount of payment, and, in the case of ongoing monthly adoption assistance payments, that such payments are subject to review at least annually and may be readjusted as set forth in subsection (g) above. In order to receive adoption assistance, the child must be placed in the adoptive home and the adoption assistance agreement signed prior to finalization of the adoption.

i) The type(s), amount and duration of adoption assistance shall be agreed to in writing by the Department and the adoptive parent(s) prior to the finalization of the adoption, and shall be set forth in the adoption assistance agreement, which shall be binding on the parties to the agreement. The agreement shall also stipulate that the agreement shall remain in effect regardless of the state where the adoptive parents reside currently or in the future and shall contain

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provisions for the protection of the interests of the child in cases where the adoptive parents and child move to another state while the agreement is in effect. The duration of adoption assistance may not extend beyond age 18 years (for children for whom the adoption assistance agreement was negotiated on or after November 28, 1995), although adoption assistance may be provided at the Department's option until the child's 21st birthday if the child has a physical, mental or emotional handicap that warrants the continuation of assistance and the child is not eligible for other benefits.

i) The adoptive parent(s) shall notify the Department as soon as practically possible in writing when the following changes occur which will affect the amount of adoption assistance:
   1) the child is no longer the legal responsibility of the adoptive parent(s);
   2) the child is no longer receiving financial support from the adoptive parent(s);
   3) the child no longer requires adoption assistance for the special needs for which adoption assistance was being provided;
   4) the child becomes eligible for any benefit payments that would affect the monthly payment, such as Social Security benefits, Supplemental Security Income (SSI) benefits, Veteran's benefits, railroad retirement or black lung benefits, financial settlements, payments, inheritance or gifts;
   5) a change has occurred in the circumstances of the family that is relevant in determining the amount of assistance payments; or
   6) there is a change of address.

~~a) Adoption assistance, also known as adoption subsidy, shall be offered to persons adopting special needs children:~~
   ~~1) for whom the Department is legally responsible, or for whom the Department is not legally responsible who were eligible for Aid to Families with Dependent Children (AFDC) at the time the adoption petition was filed or who were eligible for Supplemental Security Income (SSI) prior to finalization of the adoption; and~~
   ~~2) who are legally free for adoption; and~~
   ~~3) who cannot or should not be returned to their parents' homes as determined by the standards delineated in 89 Ill. Adm. Code 305.100; and~~
   ~~4) for whom adoption without adoption assistance is unlikely or has been unsuccessful; and~~
   ~~5) who have been placed in the adoptive home and for whom an adoption assistance agreement, in accordance with subsection (e), has been signed prior to finalization of the adoption.~~
~~b) Special needs children are those:~~
   ~~1) who have irreversible or non correctable physical or mental handicaps; or~~
   ~~2) who have physical, mental or emotional handicaps correctable through surgery, treatment, or other specialized services; or~~



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   ~~3) who are 6 years of age or older; or~~
   ~~4) who are 3 years of age or older and are members of racial minorities; or~~
   ~~5) who are members of a sibling group who are being placed together where at least one child meets one or more of the above criteria.~~
~~c) Types and amounts of adoption assistance are based on the needs of the child and may include:~~
   ~~1) ongoing monthly payments not to exceed 5% less than the foster family care payment level which had been received or would be received if the child were in foster care as adjusted in accordance with subsection (d) below;~~
   ~~2) one time only payment for services related to legally completing the adoption;~~
   ~~3) payments for those physical, emotional and mental health needs which are not wholly payable through insurance or other public resources and which are associated with or result from a medical condition(s) whose onset has been established as occurring prior to the completion of the adoption.~~
~~d) A prospective adoptive family being presented with a child determined to be a special needs child shall be made aware of the availability of adoption assistance, the types of assistance available, the amount of payment which may be available, based on the needs, age, and placement of the child and adjusted for any benefits, such as Social Security or Veteran's benefits which the child will be receiving.~~
~~e) The type(s), amount and duration of adoption assistance shall be agreed to in writing by the Department and the adoptive parent(s) prior to the finalization of the adoption. The duration of adoption assistance may not extend beyond age 18 years (for children adopted after the effective date of this Part) unless the child has a mental or physical disability. If the child adopted after the effective date of this Part has a mental or physical disability and other assistance is not available, the assistance may be provided to age 21.~~
~~f) The adoptive parent(s) shall notify the Department when:~~
   ~~1) they are no longer legally responsible for the support of the child; or~~
   ~~2) the child is no longer receiving any financial support from the adoptive parent(s); or~~
   ~~3) the conditions for which periodic services were needed have changed; or~~
   ~~4) the family has received notification of child's eligibility for certain benefits such as, social security, SSI, Veterans, railroad retirement or black lung benefits, etc. and the family has been named payee.~~
~~g) Adoption assistance payments shall be adjusted to reflect the above changes in circumstances. The Department shall annually review with the adoptive parent(s) the continuing need of the child for adoption assistance. Any adjustment in adoption assistance payments shall be made with prior written notice to the adoptive parent(s).~~

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NOTICE OF EMERGENCY AMENDMENTS

(Source: Emergency amendment at 19 Ill. Reg. 16735, effective November 28, 1995, for a maximum of 150 days)

**Section 302.311 Nonrecurring Adoption Expenses (Repealed)**
**EMERGENCY**

~~a) Payment of nonrecurring adoption expenses, up to a maximum of $1500.00 per adopted child, is available to any family:~~
~~1) who adopts a special needs child as defined in Sections 302.310 (a)-(3)-(6) and 302.310 (b), and the child's adoption was:~~
~~A) handled directly through the Department or through another public or a non-profit private agency or independently, and~~
~~B) initiated or finalized in Illinois.~~
~~b) Payment for nonrecurring adoption expenses are reimbursable only when the Department has a signed agreement with the adopting parent(s) prior to the finalization of the adoption, unless the adoption decree was entered into~~
~~1) on or after January 1, 1987 but prior to June 14, 1989, or~~
~~2) before January 1, 1987, but the adoption expenses were paid after January 1, 1987.~~
~~c) This provision does not include nonrecurring adoption expenses which have been reimbursed through another state or federal program. Allowable nonrecurring adoption expenses include, but are not limited to, adoption fees, court costs, attorney fees, and other expenses (e.g., health and psychological examinations and costs associated with preplacement visits) which are not incurred in violation of State or Federal laws (e.g., "AN ACT in relation to the adoption of persons and to repeal an act therein named" (Ill. Rev. Stat. 1987, ch. 40, par. 1501 et seq.) or the Adoption Assistance and Child Welfare Act of 1980 (42 U.S.C.A. 670 et seq. (1980 Supp.)).~~

(Source: Emergency repealed at 19 Ill. Reg. 16735, effective November 28, 1995)



JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

The following second notices were received by the Joint Committee on Administrative Rules during the period of November 28, 1995 through December 4, 1995 and have been scheduled for review by the Committee at its December 12, 1995 meeting. Other items not contained in this published list may also be considered. Members of the public wishing to express their views with respect to a rule should submit written comments to the Committee at the following address: Joint Committee on Administrative Rules, 700 Stratton Bldg., Springfield, IL 62706.

| Second Notice Expires | Agency and Rule | Start of First Notice | JCAR Meeting |
|---|---|---|---|
| 1/11/96 | Department of Commerce and Community Affairs, State Administration of the Federal Community Services Block Grant Program (47 Ill Adm Code 120) | 9/22/95 19 Ill Reg 13127 | 12/12/95 |
| 1/11/96 | Department of Natural Resources, Duck, Goose and Coot Hunting (17 Ill Adm Code 590) | 10/6/95 19 Ill Reg 13681 | 12/12/95 |
| 1/11/96 | Department of Children and Family Services, Appeal of Foster Family Home License Denials by Relative Caregivers (89 Ill Adm Code 338) | 9/1/95 19 Ill Reg 12408 | 12/12/95 |
| 1/12/96 | Commissioner of Savings and Residential Finance, Residential Mortgage License Act of 1987 (38 Ill Adm Code 1050) | 10/13/95 19 Ill Reg 14348 | 12/12/95 |
| 1/12/96 | Department on Aging, Community Care Program (89 Ill Adm Code 240) | 9/8/95 19 Ill Reg 12563 | 12/12/95 |
| 1/13/96 | Department of State Police Merit Board, Procedures of the Department of State Police Merit Board (80 Ill Adm Code 150) | 10/6/95 19 Ill Reg 13834 | 12/12/95 |
| 1/13/96 | Department of Professional Regulation, Optometric Practice Act of 1987 (68 Ill Adm Code 1320) | 10/6/95 19 Ill Reg 13721 | 12/12/95 |
| 1/14/96 | Department of Public Health, Illinois Home Health Agency Code (77 Ill Adm Code 245) | 8/4/95 19 Ill Reg 11325 | 12/12/95 |

JOINT COMMITTEE ON ADMINISTRATIVE RULES
ILLINOIS GENERAL ASSEMBLY

SECOND NOTICES RECEIVED

| | | | |
|---|---|---|---|
| 1/14/96 | Department of Public Health, Hospital Licensing Requirements (77 Ill Adm Code 250) | 7/21/95 19 Ill Reg 10407 | 12/12/95 |
| 1/14/96 | Department of Public Health, Emergency Medical Services and Trauma Center Code (77 Ill Adm Code 515) | 10/6/95 19 Ill Reg 13823 | 12/12/95 |
| 1/14/96 | Department of Public Health, Tanning Facilities Code (77 Ill Adm Code 795) | 8/11/95 19 Ill Reg 11444 | 12/12/95 |



PROCLAMATIONS

95-562
HIGH TECHNOLOGY WEEK

Whereas, the State of Illinois salutes the 12th annual Illinois High Tech Awards, established by KPMG Peat Marwick to honor high tech entrepreneurs who have made significant contributions to the development of technology in the state; and

Whereas, high tech entrepreneurs will be honored on November 20, 1995, at the Ritz-Carlton Hotel in Chicago, when winners and finalists who have successfully organized, developed, or managed a high technology concept into a commercial product will be announced; and

Whereas, KPMG Peat Marwick, one of the world's largest professional service firms, established the awards in 1984 to encourage high technology growth in Illinois by publicizing local entrepreneurs and their success stories to encourage other business professionals to take advantage of the countless resources available locally and to strengthen the already sound business climate that exists; and

Whereas, Illinois employs 971,000 people in high technology companies, including global leaders such as Tellabs, Inc., U.S. Robotics, Inc. Zebra Technologies Corporation, and PLATINUM technology, inc.; and

Whereas, Illinois is recognized nationally for its renowned research institutes and universities including the Fermi National Accelerator Laboratory, University of Illinois, Northwestern University, Illinois Institute of Technology, University of Chicago, and Argonne National Laboratory;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim November 19-25, 1995, as HIGH TECHNOLOGY WEEK in Illinois and welcome all citizens to participate in this significant event and applaud the efforts and hard work of these entrepreneurs.

Issued by the Governor November 16, 1995.

Filed by the Secretary of State November 22, 1995.

95-563
DON R. CLEM DAY

Whereas, Don R. Clem was born on March 13, 1937, in Springfield; and

Whereas, Don R. Clem began his career with Central Illinois Light Company on June 2, 1958, and served the company with distinction in several capacities; and

Whereas, Don R. Clem became a part of the Legislative and Public Affairs Department on February 1, 1989; and

Whereas, Don R. Clem has become one of the most respected and effective legislative affairs representatives in the eyes of the Illinois General Assembly; and

Whereas, Don R. Clem has been elevated to a position of leadership among his colleagues and peers; and

Whereas, Don R. Clem will retire on December 31, 1995, after 37 years of service with Central Illinois Light Company;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim December 31, 1995, as DON R. CLEM DAY in Illinois in honor of his accomplishments and his dedicated service to Central Illinois Light Company.

Issued by the Governor November 17, 1995.
Filed by the Secretary of State November 22, 1995.

**95-564**
**C. RICHARD NEUMILLER DAY**

Whereas, C. Richard Neumiller was born on November 9, 1931, in Peoria; and

Whereas, he graduated Phi Beta Kappa, Cum Laude, from Knox College in Galesburg; and

Whereas, he served in the U.S. Army as a company commander in the 10th Mountain Infantry Division; and

Whereas, C. Richard Neumiller was Vice-President and General Manager of Humitube Manufacturing Company from 1957 until 1966; and

Whereas, he joined Central Illinois Light Company in 1967, rising to the position of Director of Legislative and Public Affairs in 1981; and

Whereas, he served the City of Peoria as Mayor and City Councilman and was most recently appointed to serve as a commissioner for the Illinois Student Assistance Commission; and

Whereas, C. Richard Neumiller has compiled a long list of accomplishments and community service achievements; and

Whereas, C. Richard Neumiller will retire on December 31, 1995, after 29 years of service with Central Illinois Light Company;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim December 31, 1995, as C. RICHARD NEUMILLER DAY in Illinois in honor of his accomplishments, his public service and his service to Central Illinois Light Company.

Issued by the Governor November 17, 1995.
Filed by the Secretary of State November 22, 1995.

**95-565**
**DR. JOHN T. BENKA**

Whereas, Dr. John T. Benka received a Ph.D. in Educational Administration from the University of Wisconsin-Madison in August 1972, a master's degree in Educational Administration, Curriculum and Supervision from the University of Wisconsin-Milwaukee in August 1965, and a bachelor's degree in Biology and English from Ripon College in June 1960; and

Whereas, Dr. Benka has made many professional achievements in his area of expertise; and

Whereas, Dr. Benka has served as Assistant Superintendent and Acting Superintendent for the Maine Township High School District 207, Assistant Superintendent for Instruction for Milton Area Schools, Principal for Milton Senior High School, and Assistant Principal for Franklin Senior High School; and

Whereas, he has been a teacher at several high schools and an adjunct professor for National Louis University; and

Whereas, he also has served on a variety of boards and committees, and he has been awarded honors such as Northwestern University's Phi Delta Kappa Recognition Award for Organizational Leadership and the Illinois State Board of Eduation's Those Who Excel Award of Merit; and

Whereas, Dr. John T. Benka retired from Main Township High School



District 207 on September 29, 1995, after 22 years of distinguished service;

Therefore, I, Jim Edgar, Governor of the State of Illinois, recognize DR. JOHN T. BENKA for his many accomplishments and for his dedication to the education and well-being of students in Illinois.

Issued by the Governor November 20, 1995.
Filed by the Secretary of State November 22, 1995.

**95-566**
**FAMILY WEEK**

There's no vocabulary For love within a family, love that's lived in But not looked at, love within the light of which All else is seen, the love within which All other love finds speech. This love is silent. Eliot, The Elder Statesman, 1958

Whereas, the family is the entity that nurtures the values which have made America great. The bonds of familial love are the foundation of our nation's strength; and

Whereas, the trust, duty, respect, and cooperation that are a way of life for family members are traits that reinforce the fabric and function of all societal units from the neighborhood to the nation. The acceptance of each individual family member's uniqueness, teamed with simultaneous, unified strides to improve gives momentum to our progress as a nation; and

Whereas, appropriately placed with the traditional week of Thanksgiving, National Family Week is a period of thanks for all the contributions the family has made to our country;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim November 19-25, 1995, as FAMILY WEEK in Illinois in conjunction with the national observance.

Issued by the Governor November 20, 1995.
Filed by the Secretary of State November 22, 1995.

**95-567**
**INTERNATIONAL HOUSEWARES DAY**

Whereas, The Board of Directors of the National Housewares Manufacturers Association has chosen our state for its 99th International Housewares Show; and

Whereas, Illinois has hosted the nation's premier housewares show since 1928; and

Whereas, the American housewares industry represents more than $54.4 billion in annual retail sales and is actively involved in export activities; and

Whereas, the National Housewares Manufacturers Association's 1996 International Housewares Show is the largest U.S. marketplace for the buying and selling of housewares products; and

Whereas, the world's largest "homewares-only" exposition brings 11,000 American buyers and 4,600 buyers from 95 other countries to Illinois to purchase goods from 2,000 housewares exhibitors; and

Whereas, the International Housewares Show attracts more than 55,000 people to Illinois;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim January 14-17, 1996, as INTERNATIONAL HOUSEWARES DAYS in Illinois and welcome

the International Housewares Show to our state.

Issued by the Governor November 20, 1995.

Filed by the Secretary of State November 22, 1995.

95-568
KNIGHTS OF DABROWSKI DAY

Whereas, the original founders of the Knights of Dabrowski were Polish children orphaned by World War II who were deported to Russia and Germany; and

Whereas, on November 11, 1945, the BishopFEs relief Committee brought 31 teenagers to Orchard Lake and gave them a home and education; and

Whereas, these children formed the Kolo Chlopcow z Polski fraternity whose aim was to support the Orchard Lake Schools; and

Whereas, in 1969, the organization honored the founder of Orchard Lake Schools and changed its name to Knights of Dabrowski in order to promulgate the ideals of Father Joseph Dabrowski; and

Whereas, The Crusade for Education was initiated in 1973 by the late Dr. Edward Wajda in order to support higher education by providing scholarships; and

Whereas, over 450 scholarships exceeding $550,000 have been awarded attesting to the generosity of the community and the tireless efforts of the organization's members; and

Whereas, the Knights of Dabrowski organization is celebrating its 50th Anniversary in 1995;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim November 27, 1995, as KNIGHTS OF DABROWSKI DAY in Illinois.

Issued by the Governor November 20, 1995.

Filed by the Secretary of State November 22, 1995.

95-569
VETERANS DAY

Whereas, the men and women who have served in the Armed Forces of the United States of America have made major contributions toward the preservation of the freedom of this nation and its people; and

Whereas, the services performed by these millions of gallant Americans have demonstrated the willingness of our nation and its people; and

Whereas, the Congress of the United States of America has designated the 11th day of November of each year as Veterans Day; and

Whereas, Veterans Day has become a significant part of our national heritage as we recognize the important contributions of the millions of our citizens whose military service has had a profound effect on history; and

Whereas, the unselfishness of all those who served in the United States Armed Forces is a quality for which we are all grateful; and

Whereas, this year the week of November 4-11, 1995, has been designated as the official commemoration of the 50th anniversary of the end of World War II;

Therefore I, Jim Edgar, Governor of the State of Illinois, proclaim November 11, 1995, as VETERANS DAY in Illinois in conjunction with the national observance and in honor of the 50th anniversary of the end of World War II. I ask that the day be observed with appropriate ceremonies in honor of those who have served the national purpose to preserve the principles of justice, freedom, and democracy.

Issued by the Governor November 8, 1995.

Filed by the Secretary of State December 1, 1995.



95-570
GRANT A WISH DAY

Whereas, in 1981, Anne Blair founded the Grant A Wish Program, dedicated to granting wishes to needy, disabled and abused children of all ethnic backgrounds in and around the Chicago area; and

Whereas, the Grant A Wish Program is committed to and proactively works in the best interest and welfare of children; and

Whereas, the main objective of the program is to uplift the quality of life for children who are trying to attend school but do not have the necessary resources at home to support their objectives; and

Whereas, in 1981, the program provided for 50 children; and

Whereas, through their dedication and community sponsorship, 5,600 children were aided in 1994; and

Whereas, it is right and just to show our appreciation for the efforts of the dedicated Board, staff, and volunteers;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim November 21, 1995, as GRANT A WISH DAY in Illinois.

Issued by the Governor November 22, 1995.

Filed by the Secretary of State December 1, 1995.

95-571
HOME SAFETY WEEK

Whereas, accidents in the home, including accidental carbon monoxide poisoning, are most likely to result in disabling injury, illness, or death; and

Whereas, effective safety education and awareness have significantly reduced the number of accidental home deaths over the years; and

Whereas, the NICOR Energy Services, a sister company of Northern Illinois Gas, which provides preventive safety inspection plans and heating equipment service contracts through approved, independent contractors, is concerned about the dangers of carbon monoxide poisoning, its sources, what a homeowner can do to prevent it, and what steps should be taken in case of an emergency; and

Whereas, Northern Illinois Gas, in cooperation with NICOR Energy Services, is introducing a consumer awareness safety campaign called, "Safe at Home," that includes information on carbon monoxide prevention, natural gas safety, tips for home equipment maintenance, tips for selecting and working with qualified service contractors, and safety tips for senior citizens; and

Whereas, "Safe at Home" kits, including videos on CO and home equipment maintenance and safety, will be provided to the public, fire departments, community libraries, and other organizations to inform them of possible hazards in the home;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim December 3-9, 1995, as SAFE AT HOME WEEK in Illinois.

Issued by the Governor November 22, 1995.

Filed by the Secretary of State December 1, 1995.

95-572
SAFE AT HOME WEEK

Whereas, accidents in the home, including accidental carbon monoxide poisoning, are most likely to result in disabling injury, illness, or death; and

Whereas, effective safety education and awareness have significantly reduced the number of accidental home deaths over the years; and

Whereas, the NICOR Energy Services, a sister company of Northern Illinois Gas, which provides preventive safety inspection plans and heating equipment service contracts through approved, independent contractors, is concerned about the dangers of carbon monoxide poisoning, its sources, what a homeowner can do to prevent it, and what steps should be taken in case of an emergency; and

Whereas, Northern Illinois Gas, in cooperation with NICOR Energy Services is introducing a consumer awareness safety campaign called, "Safe at Home," that includes information on carbon monoxide prevention, natural gas safety, tips for home equipment maintenance, tips for selecting and working with qualified service contractors, and safety tips for senior citizens; and

Whereas, "Safe at Home" kits, including videos on CO and home equipment maintenance and safety, will be provided to the public, fire departments, community libraries, and other organizations to inform them of possible hazards in the home;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim December 3-9, 1995, as SAFE AT HOME WEEK in Illinois.

Issued by the Governor November 22, 1995.

Filed by the Secretary of State December 1, 1995.

95-573
GEOGRAPHY AWARENESS WEEK

Whereas, Geography is the study of where things are and how they got there; and

Whereas, this year, Geography Awareness Week emphasizes other people and cultures; and

Whereas, this dedicated week encourages everyone to learn about the people and places that make up our very interesting world; and

Whereas, this education will allow our younger citizens the chance to respect people and things from all parts of the globe;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim November 12-18, 1995, as GEOGRAPHY AWARENESS WEEK in Illinois.

Issued by the Governor November 27, 1995.

Filed by the Secretary of State December 1, 1995.

95-574
TRAVELERS WITH DISABILITIES AWARENESS WEEK

Whereas, the Americans with Disabilities Act (ADA) gives civil rights protection to, and guarantees equal opportunity for, individuals with disabilities in employment, public accommodations, transportation, State and local government services, and telecommunications; and

Whereas, increasing numbers of persons with disabilities are traveling, touring, and enjoying hospitality services and leisure activities; and



Whereas, the Travel Industry has formed a Partnership in Awareness comprised of American Express, American Airlines, American Bus Association (ABA), American Hotel and Motel Association (AH&MA), the American Society of Travel Agents (ASTA), Africa Travel Association (ATA), Assembly of National Tourist Office Representatives (ANTOR), Association of Retail Travel Agents (ARTA), Greyhound Lines Inc., Hilton Hotel Corporation, Hertz, International Association of Convention and Visitors' Bureaus (IACVB), National Tour Association of America (NTA), Princess Cruises, Travel Industry Association of America (TIA) and the Society for the Advancement of Travel for the Handicapped (SATH); and

Whereas, the State of Illinois seeks to promote respect and equal opportunities for all persons;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim November 26-December 3, 1995, as TRAVELERS WITH DISABILITIES AWARENESS WEEK in Illinois and encourage all citizens involved in the travel industry to respect travelers with disabilities, become aware of their needs and provide them with accessibility to activities and accommodations.

Issued by the Governor November 27, 1995.

Filed by the Secretary of State December 1, 1995.

95-575
AIDS AWARENESS DAY

Whereas, the prevention of HIV infection and AIDS necessitates a worldwide effort to increase communication, education and preventive action to stop the transmission of HIV and the spread of AIDS; and

Whereas, the World Health Organization now estimates worldwide that 18.5 million people have been infected with HIV and 4.5 million of them have developed AIDS; and

Whereas, in Illinois, the number of AIDS cases has reached nearly 16,000 with more than 60 percent of these lives lost to this devastating disease; and

Whereas, the World Health Organization has designated December 1 of each year as World AIDS Day, a day to expand and strengthen the worldwide effort to stop the spread of HIV and AIDS; and

Whereas, World AIDS Day 1995, "Shared Rights and Responsibilities," urges the world to protect everyone's rights to HIV/AIDS prevention and care; recognizes that everyone shares the same human rights regardless of their HIV status; and emphasizes the shared responsibilities of individuals, families, governments and the international community to promote prevention; and

Whereas, this day in Illinois is commemorated by a number of events across the state, including the dimming of the lights atop the Illinois State Capitol dome and at the James R. Thompson Center in Chicago during the evening hours to coincide with the dimming of the lights of the White House, to offer a tribute to those infected and affected by HIV and AIDS;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim December 1, 1995, as AIDS AWARENESS DAY in Illinois and urge all citizens to take part in activities and observances designed to increase awareness and understanding of AIDS, to take part in AIDS prevention activities and programs, and to join in the efforts to prevent transmission of HIV and further spread of AIDS.

Issued by the Governor November 28, 1995.

Filed by the Secretary of State December 1, 1995.

## 95-576
## DRUNK AND DRUGGED DRIVING PREVENTION MONTH

Whereas, more violent deaths are attributed to traffic crashes than any other cause; and

Whereas, in 1994, 1,554 traffic fatalities occurred in Illinois; and

Whereas, approximately 37 percent of fatally injured drivers whose blood was tested have alcohol concentration levels above the legal limit; and

Whereas, reports of motor vehicle crashes involving drivers who have used illegal drugs also are increasing; and

Whereas, while estimates for property damage from drunk driving crashes are in the hundreds of millions of dollars, the cost of drunk driving to society is truly inestimable when the suffering of innocent victims is taken into consideration; and

Whereas, citizens deserve a solution to this nationwide health and safety threat; and

Whereas, such a solution requires the cooperation of all levels of government and business as well as the general public; and

Whereas, the holiday season, traditionally a time of increased crashes, is an appropriate time to focus attention on both the problem and its solution;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim December 1995 as DRUNK AND DRUGGED DRIVING PREVENTION MONTH in Illinois in conjunction with the national observance.

Issued by the Governor November 29, 1995.

Filed by the Secretary of State December 1, 1995.

## 95-577
## GREAT CITIES DAY

Whereas, cities have been centers of creativity and influence, generating knowledge and wealth that made our nation an economic and political power; and

Whereas, cities also face major challenges such as unemployment, schooling, crime and inadequate health care; and

Whereas, improvement in the quality of life in urban areas requires a comprehensive approach that addresses interrelated problems at the same time; and

Whereas, this integrated approach is the philosophy behind the Great Cities initiative at the University of Illinois at Chicago; and

Whereas, Great Cities is an institutional commitment to address human needs in Chicago and in metropolitan areas worldwide by becoming a partner with government and public agencies, corporations, and philanthropic and civic organizations; and

Whereas, UIC, a leading public university in a major city, produces exciting breakthroughs in the physical and social sciences and the arts and this program extends UIC's historic strengths in fields relevant to urban areas;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim December 1, 1995, as GREAT CITIES DAY in Illinois.

Issued by the Governor November 29, 1995.

Filed by the Secretary of State December 1, 1995.

## 95-578 CHICAGO METROPOLITAN BOWLING ASSOCIATION MONTH



Whereas, on January 13, 1896, Chicago became a Charter Member of the American Bowling Congress, which was then formed as the governing body of the sport of bowling in North America; and

Whereas, Chicago Bowling Association/Chicago Metropolitan Bowling Association of the American Bowling Congress is celebrating its 100th anniversary; and

Whereas, the Chicago Metropolitan Bowling Association Board of Directors, comprised mainly of volunteers, serves the recreational needs of all bowlers throughout Chicago and surrounding areas; and

Whereas, the Chicago Metropolitan Bowling Association's 100th Anniversary and the American Bowling Congress' Centennial celebrations will bring recognition to the sport of bowling and to local membership organizations, proprietors and manufacturers;

Therefore, I, Jim Edgar, Governor of the State of Illinois, proclaim January 1996 as CHICAGO METROPOLITAN BOWLING ASSOCIATION MONTH in honor of the association's 100th anniversary.

Issued by the Governor November 30, 1995.

Filed by the Secretary of State December 1, 1995.

## 95-579
## LINCOLN AWARD FOR BUSINESS EXCELLENCE ESTABLISHED

Whereas, the quality of Illinois products and services are essential to Illinois' success in today's highly competitive, global economy; and

Whereas, the businesses that emphasize quality are those that are most competitive in the worldwide marketplace; and

Whereas, Illinois educational institutions must establish and meet standards of quality instruction if they are to produce graduates capable of life-long employment and productivity; and

Whereas, Illinois government agencies must also place emphasis on quality if they are to deliver effective and efficient service; and

Whereas, we in Illinois encourage Illinois business organizations, educational institutions, and government agencies to pursue total quality in all they do; and

Whereas, the Lincoln Award for Business Excellence, patterned after the Malcom Baldrige National Quality Award, will recognize the achievements of those organizations which implement a total quality philosophy and improve the quality of their products and services, providing an example for others to follow. The program will promote the continued improvement of quality, customer satisfaction, and global competitiveness of Illinois organizations by educating Illinoisans about quality improvement, fostering the pursuit of quality in all aspects of Illinois life, and recognizing excellence in quality leadership; and

Whereas, the Lincoln Award for Business Excellence will be administered by the Lincoln Award for Business Excellence Foundation, a privately funded, not-for-profit organization whose goal is to promote quality in industry, services, health care, education, and government throughout Illinois;

Therefore, I, Jim Edgar, Governor of the State of Illinois, applaud the recent initiative by several Illinois businesses to establish a Lincoln Award for Business Excellence and wish them success in their venture.

Issued by the Governor November 30, 1995.

Filed by the Secretary of State December 1, 1995.

Rules acted upon during the quarter of October 1 through December 31, 1995 are listed in the Issues Index by Title number, Part number and Issue number. For example, 32 Ill. Adm. Code 610 published in Issue 42 will be listed as 32-610-42. This Issues Index supplements the Sections Affected and Cumulative Indexes published in the October 13, 1995 Illinois Register (Issue 41). Inquiries about the Issues Index may be directed to the Administrative Code Division at 217-782-7017.

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